Humana – CareSource Provider Manual

Humana® CareSource®

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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.

At Humana – CareSource, we call healthcare providers our health partners. A "health partner" is any healthcare provider who participates in Humana – CareSource's provider network. You may find "health partner" and healthcare provider used interchangeably in our manual, agreements and website.

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 providers to offer the services our members need to be healthy.

As a managed care organization (MCO), Humana – CareSource improves the health of our members by utilizing a contracted network of high-quality providers. Primary care providers (PCPs) within the network provide a range of services to our members and coordinate patient care by referring them to specialists when needed and ensuring timely access to healthcare services and 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

Humana — the nation's premier health benefits innovator with roots in Kentucky — 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, one of the nation's largest Medicaid managed care plans.

Our alliance is a strategic solution that merges the knowledge and experience of both companies to make the healthcare system work better for people eligible for both Medicare and Medicaid. Together, Humana and CareSource have the expertise, competencies and resources to make healthcare 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
- An award-winning history in member services, training, clinical programs and customer satisfaction
- The ability to scale, innovate and provide ongoing support to our extensive 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 healthcare they need, when they need it. Through community-based partnerships and services, we help our members successfully navigate complex healthcare 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
- Claim 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 via 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 & Benefits section of this manual.

Compliance and Ethics

At Humana – CareSource, we serve a variety of audiences: members, 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 and 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

Following are general compliance and ethics expectations for 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
- Notify us 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.

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.

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.

Hours of Operation

Provider Services: Monday through Friday, 8 a.m. to 6 p.m. Eastern time.

Member Services: Monday through Friday, 7 a.m. to 7 p.m. Eastern time

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 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.

Provider Relations	1-855-852-7005	8 a.m. to 5 p.m. Eastern time
Provider Services	1-855-852-7005	8 a.m. to 6 p.m. Eastern time
Prior Authorizations	1-855-852-7005	8 a.m. to 6 p.m. Eastern time
Behavioral Health Crisis Line	1-877-380-9729	24 hours a day, 7 days a week 365 days a year
Care Management	1-866-206-0272	8 a.m. to 6 p.m. Eastern time
Claim Inquiries	1-855-852-7005	8 a.m. to 6 p.m. Eastern time
Credentialing	1-855-852-7005	8 a.m. to 5 p.m. Eastern time
Member Services	1-855-852-7005	7 a.m. to 7 p.m. Eastern time
24-Hour Nurse Advice Line	1-866-206-9599	24/7/365
Fraud, Waste and Abuse Hotline*	1-855-852-7005	24/7/365 (voicemail)
TTY for the Hearing Impaired	1-800-648-6056 or 711	24/7/365

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

Fax

Care 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.*

Mail

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

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

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

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

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

Please visit our Appeals webpage at **CareSource.com** > Providers > Provider Portal > Provider Appeals, selecting Kentucky Medicaid, for more information about submitting appeals online.

Website

Accessing our website, at CareSource.com/ky/providers/medicaid/, is quick and easy. Our provider pages provide access to frequently used forms, newsletters, updates and announcements, our provider manual, claim information, frequently asked questions and much more.

Provider Portal

Our secure online Provider Portal at **CareSource.com** > Login > Provider, selecting Kentucky, allows 24/7/365 access to valuable information, self-service features and resources and tools. 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.

Benefits

The provider portal affords you the following benefits:

- An encrypted tool that allows you to easily access time-saving services and critical information
- Available 24 hours a day, seven days a week
- Accessible on personal computers without additional software

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 healthcare 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
- Clinical Practice Registry — View and sort Humana – CareSource members into actionable groups for improved focus on preventive care, testing or other services (e.g., well-baby visits, diabetes, asthma and more)

Registration

If you are not registered with the Humana – CareSource Provider Portal, please follow these easy steps:

1. Go to the Provider Portal at **CareSource.com** > Login > Provider, select Kentucky, click the Register Now button and complete the three-step registration process. **Note:** You will need 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. **Note:** If you do not remember your user name/password, you can call Provider Services at **1-855-852-7005**.

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 **CareSource.com** > Providers > Education > Newsletters & Communications, selecting Kentucky Medicaid, to access previous issues of 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 at **CareSource.com** > Providers > Tools & Resources > Updates & Announcements, selecting Kentucky Medicaid.

Demographic Changes

Advance written notice of status changes, such as changes to your address or phone number or adding or deleting a provider to your practice, helps us keep our records current and is critical for claim processing. Please submit changes promptly via the following methods:

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

Email: providerdevelopmentkywv@humana.com

Fax: 1-800-626-1686

MEMBER ENROLLMENT & ELIGIBILITY

Medicaid Eligibility

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.

Newborn Enrollment

Humana – CareSource begins coverage of newborns on the 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.

You can verify eligibility for a newborn on the Provider Portal at **CareSource.com** > Login > Provider, selecting Kentucky from the menu. Refer to the Verify Eligibility section for instructions.

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.

Member disenrollment can be initiated for the following reasons:

- 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. 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.

Involuntary Dismissal

Participating 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
- Violating no-show office policies
- Failing 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's office must notify the member of the dismissal by certified letter. The letter should include the reason for which the disenrollment is requested and the specific dates of the three documented unsuccessful education attempts.
- A copy of the letter must be sent or faxed to Humana – CareSource at the following address:

  Mail: Humana – CareSource
  Attn: Service Operations Resolution Team (SORT)
  P.O. Box 221529
  Louisville, KY 40252-1529

  Fax: 1-937-226-6916

For PCPs only, the letter must contain the following specific language:

- The member must contact Humana – CareSource member services to choose another PCP
- The reason for which the disenrollment is requested should include at least one of the following:
  - Incompatibility of the PCP/patient relationship;
  - Patient has not utilized a service within one year of enrollment in the PCP's practice and will include the specific dates of documented unsuccessful contact attempts by mail and phone on at least six (6) separate occasions during the year; or
  - Inability to meet the medical needs of the patient.
- The dismissing PCP shall serve until the new PCP begins serving the patient barring ethical or legal issues.

Referrals for Release Due to Ethical Reasons

Humana – CareSource providers are not required to perform any treatment or procedure that is contrary to the provider's conscience, religious beliefs, or ethical principals in accordance with 42 C.F.R 438.102.

The provider shall refer the member to another provider who is licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition. The provider must be actively enrolled with the Commonwealth of Kentucky to provide Medicaid services to beneficiaries. The provider also must be in Humana – CareSource's provider network.

In such circumstance, where the provider's conscience, religious beliefs, or ethical principals require involuntary dismissal of the member as his/her physician, the provider's office must notify the member of the dismissal by certified letter. The letter should include:

- The reason for which the disenrollment is requested.
- Referral to another provider licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition. The provider must be actively enrolled with the Commonwealth of Kentucky to provider Medicaid services to beneficiaries. The provider also must be in Humana – CareSource's provider network.
- Instructions to contact Humana – Caresource member services at **1-855-852-7005** for assistance in finding a preferred in-network provider.
- A copy of the letter must be sent or faxed to Humana – CareSource at the following address:

  Mail: Humana – CareSource
  Attn: Service Operations Resolution Team (SORT)
  P.O. Box 221529
  Louisville, KY 40252-1529

  Fax: 1-937-226-6916

Please call Provider Services at **1-855-852-7005** if you have questions about disenrollment reasons or procedures.

Automatic Renewal

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.

New Member 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.

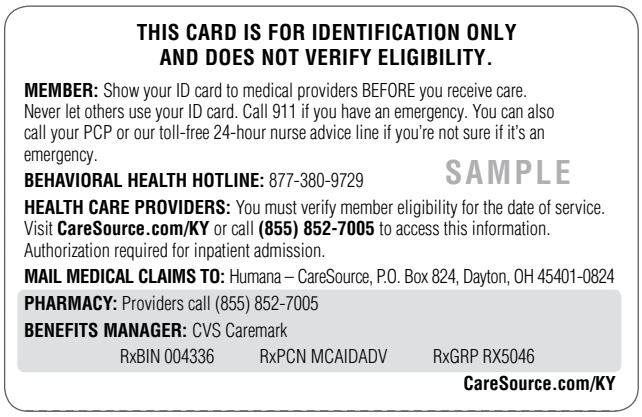
The new member kit contains:

- Information on how to obtain a copy of the Humana – CareSource provider directory
- A member handbook which explains how to access plan services and benefits
- A health assessment survey
- Other preventive health education materials and information

Member ID Cards

All new Humana – CareSource members receive a Humana – CareSource member ID card. 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.



Card Front:

- **Member Name**
- **Date of Birth:** Member's date of birth
- **Humana – CareSource Member ID #:** Use this number on claims.
- **Medicaid ID #:** Please do not use this number to bill Humana – CareSource.
- **Primary Care Provider/Clinic Name:** Each member chooses a participating provider to be his or her primary care provider (PCP). If a choice is not made, a PCP is assigned.
- **Member Services:** Phone number and TTY for the hearing impaired.
- **24-hour nurse line:** Phone number to reach a registered nurse 24/7/365

Card Back:

- **Behavioral Health Hotline:** Members can call this hotline 24/7/365 for mental health or addiction services.
- **Website:** Our website contains plan information and access to special functionality, like eligibility verification, claim and prior authorization submission, COB check and more.
- **Health Care Provider Services:** Use this toll-free phone number if you have questions or wish to verify eligibility over the phone.
- **Mail Medical Claims to:**
  Humana – CareSource
  P.O. Box 824
  Dayton, OH 45402-0824
- **Pharmacy:** Call Provider Services or contact CVS Caremark if you have questions about pharmacy benefits and services.

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.

Verify Eligibility

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.

Before providing all services EXCEPT emergency services, providers are expected to verify member eligibility via HealthNet Portal which can be accessed at www.kymmis.com.

HealthNet

HealthNet is the commonwealth's web portal for access to member eligibility, managed care organization enrollment and cost share requirement validation information. It contains many of the tools necessary for member administrative tasks. To access HealthNet, visit www.kymmis.com/kymmis/index.aspx. Registration is necessary.

HealthNet will display the member's date of eligibility, termination, cost share requirement, the managed care organization for which they are enrolled, and the Medicaid plan.

Providers also have access to verification resources on the Humana – CareSource provider portal: Log on to the Provider Portal at **CareSource.com** > Login > Provider, selecting Kentucky from the menu.

- You can check Humana – CareSource member eligibility up to 24 months after the date of service. You can search by date of service plus 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 in to our secure provider portal at **CareSource.com** > Login > Provider, selecting Kentucky from the menu, 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 one of the preceeding methods to verify member eligibility for the date of service.

MEMBER SUPPORT SERVICES & BENEFITS

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

Member Services – 1-855-852-7005 (TTY: 1-800-648-6056)

Humana – CareSource can assist members who have questions or concerns about services or benefits.

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, we 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 24 hours a day, seven days a week, 365 days a year. 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 triage system 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 can access our 24-hour nurse advice line anytime night or day. The phone number is on the member's ID card.

Disease Management

Humana – CareSource Medicaid members with chronic conditions, including asthma and diabetes, are automatically enrolled in Humana – CareSource's disease management program. Members enrolled in the program receive educational information to help them better manage their chronic conditions. Information sent to members includes care options for them to discuss with their 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.

If you have a Humana – CareSource patient with asthma or diabetes and you believe he or she would benefit from this program, please call **1-866-206-0272**.

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.

Referrals

Direct access for care management referrals and assistance with member needs is available 24 hours a day, seven days a week by calling **1-866-206-9599**. Please feel free to refer members who might need individual attention to help them manage special healthcare challenges.

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 other healthcare 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 healthcare needs
- Behavioral health and substance abuse

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 standards of practice to help members overcome healthcare access barriers. It also strengthens our provider and community resource partnerships through collaboration.

Typical high-risk members may have multiple medical issues, socioeconomic challenges and behavioral healthcare needs. The multidisciplinary care management teams are led by registered nurses (RNs) who perform a comprehensive assessment of the member's clinical status, develop an individualized treatment plan with individualized goals, monitor outcomes and evaluate those outcomes for updates to the care plan.

Prenatal 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 Care Management Support Services at **1-866-206-0272** when a member with a high-risk pregnancy is identified.

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 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 the Pregnancy Risk Assessment Form provided by Humana – CareSource. You may use your own office assessment form if you have one that captures the same information.
- When you use the Pregnancy Risk Assessment Form on our Provider Portal at CareSource.com > Login > Provider, selecting Kentucky from the menu, the information is made available to our Care Managers for outreach as necessary.
- 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 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 if 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 items in a member's record:

- Evidence of prenatal teaching — This includes education on infant feeding, the Women, Infant & Children (WIC) program, 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.

We also provide the Reproductive Life Plan assessment on the Provider Portal at **CareSource.com** > Login > Provider, selecting Kentucky from the menu, for providers to complete and attach to the member record. This provides a means for improved collaboration between the provider, member and Care Management staff.

Babies First Program

Babies First is a free program offered to pregnant members and parents or guardians of babies younger than 18 months. Through this program, members can earn up to $150 on a MyCareSource Rewards™ card.

The program focuses on encouraging pregnant members to visit their doctor for prenatal care early in their pregnancies, and then as often as their doctor recommends. Additionally, the program encourages well-baby visits as recommended to help ensure mom and baby will be as healthy as possible. Through this program, members can earn rewards and incentives for completing specific activities related to prenatal, postpartum and well-baby care. These rewards and incentives are awarded based on filed claims; members are awarded after you file a claim for the designated office visit or activity.

Upon completion and verification, the member will have the option of choosing a gift card or other limited items (e.g., baby car seat, healthy items, baby toys) from a limited selection of merchants such as Walmart or Dollar General. Regardless of the merchant selected, the rewards card will block the purchase of items such as alcohol and/or tobacco, and it cannot be converted to cash.

Members can enroll in Babies First by completing the form at https://secureforms.caresource.com/en/BabiesFirst/ky/medicaid or by callling Member Services at **1-855-852-7005**.

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.

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 brochures, and are available to explain the materials as needed. These services are available at no cost to the member or provider.

As a provider, you are required to identify the need for interpreter services for your Humana – CareSource-covered patients and offer appropriate assistance. To arrange services, submit a completed Interpreter Service Request Form found on our Forms webpage at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Kentucky Medicaid from the menu, or contact Provider Services at **1-855-852-7005**. Please inform us of members in need of interpreter services, as well as members that receive interpreter services through another resource.

Hospital Providers

Humana – CareSource requires that hospitals, at their own expense, 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 brochures, and are available to explain the materials as needed.

Hospital providers are required to identify the need for interpreter services for Humana – CareSource-covered patients and offer appropriate assistance. If you do not have access to interpreter services, contact Provider Services at **1-855-852-7005**. Please inform us of members in need of interpreter services, as well as members who receive interpreter services through another resource.

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.

COVERED SERVICES

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. Covered services may require prior authorization. Humana – CareSource provides covered services in the amount, duration and scope that is no less than the amount, duration and scope furnished to Medicaid recipients under fee-for-service program; that are reasonably expected to achieve the purpose for which the services are furnished; enables the member to achieve age-appropriate growth and development; and enables the member to attain, maintain or regain functional capacity. For a list of covered services, please refer to the Humana – CareSource member handbook available on our website at **CareSource.com** > Plans > Medicaid > Plan Documents and selecting Kentucky.

Please visit the Humana – CareSource provider website at CareSource.com/ky/providers/medicaid/ and the Provider Portal at **CareSource.com** > Login > Provider, selecting Kentucky from the menu, for information on covered services, including dental services, the member's coverage status and other information about obtaining services.

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 (i.e., 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**.

Prior Authorization

Some services require prior authorization. Humana – CareSource reviews all service requests for Medicaid members younger than 21 (from birth through the end of their 21st birth month) 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 refer to the Referrals & Prior Authorizations section of this manual for more information about referral and prior authorization procedures. Please see the Grievances & Appeals section of this manual for information on how to file an appeal.

EPSDT Program

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program developed for Medicaid recipients from birth through the end of their 21st birth month. All Humana – CareSource members within this age range should receive age-recommended EPSDT preventive exams, health screens and EPSDT special services if referrals for further diagnosis and treatment are needed to address health issues as soon as identified or suspected.

EPSDT benefits are available at no cost to members.

EPSDT Preventive Services

The EPSDT program is designed to provide comprehensive preventive healthcare services at regular age intervals. Regular EPSDT preventive visits find health issues early (including physical health, mental health, growth and developmental) so additional testing, evaluation or treatment can start right away. EPSDT preventive services are available at the recommended ages and at other times when needed.

EPSDT stresses health education to children and their caretakers related to early intervention, health and safety risk assessments at every age, referals for further diagnosis and treatment of problems discovered during exams and ongoing health maintenance.

EPSDT preventive exam components include:

- Comprehensive health and development history
- Comprehensive unclothed physical examination
- Laboratory tests, including (where indicated) blood lead level screening/testing, anemia test using hematocrit or hemoglobin determinations, sickle-cell test, complete urinalysis, testing for sexually transmitted diseases, tuberculin test and pelvic examination
- Developmental screening/surveillance, autism screening
- Sensory screenings and referrals for vision and hearing
- Nutritional assessment, including body mass index (BMI) and blood pressure
- Dental screenings and referrals to a dentist, as indicated (dental referrals are recommended to begin during a child's first year of life and are required at 2 years of age and older)
- Psychological/behavioral assessments, substance-use assessments, depression screenings
- Assessment of immunization status and administration of required vaccines
- Health education and anticipatory guidance (age-appropriate development, healthy lifestyles, accident and disease prevention, at-risk and risk behaviors and safety)
- Referral for further evaluation, diagnosis and treatment

EPSDT Exam Frequency

The recommended schedule for EPSDT preventive exams and screenings, per American Academy of Pediatrics (AAP) and Bright Futures, is as follows:

Infancy

- Less than 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months

Early Childhood

- 15 months
- 18 months
- 24 months
- 30 months
- 3 years
- 4 years

Middle Childhood

- 5 years
- 6 years
- 7 years
- 8 years
- 9 years
- 10 years

Adolescence and Young Adults

- 11 years
- 12 years
- 13 years
- 14 years
- 15 years
- 16 years
- 17 years
- 18 years
- 19 years
- 20 years
- 21 years (through the end of the member's 21st birth month)

The Humana – CareSource EPSDT Periodicity Schedule is updated to reflect current recommendations of the AAP and Bright Futures.

EPSDT Codes

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

EPSDT Office or Other Outpatient Services Codes

New Patient	Established Patient
99201	99211
99202	99212
99203	99213
99204	99214
99205	99215

The Current Procedural Terminology (CPT) code range for Office or Other Outpatient Services (99201 – 99205 or 99211 – 99215) is a medical code set maintained by the American Medical Association.

When filing claim forms using Evaluation and Management (E/M) CPT codes 99201 – 99205 or 99211 – 99215, use appropriate International Classification of Diseases, Tenth Revision (ICD-10) codes to indicate the reason for the visit as a secondary diagnosis.

Services included under these codes include measurements (length/height, head circumference, weight, BMI, blood pressure), age- and gender-appropriate exam and history (initial or interval).

To report the appropriate preventive medicine service code, first determine if the patient qualifies as new or established and then select the appropriate code within the new or established code family according to patient age.

Preventive medicine service codes are not time-based; time spent during the visit is not relevant in selecting the appropriate preventive medicine services code.

If an illness or abnormality is encountered or if a preexisting problem is addressed in the process of performing the preventive medicine service, and if the illness, abnormality or problem is significant enough to require additional work to perform the key components of a problem-oriented E/M service (history, physical examination, medical decision-making or a combination), the appropriate office or other outpatient service code (99201 – 99205 or 99211 – 99215) should be reported in addition to the preventive medicine service code.

Include modifier 25 where appropriate. Modifier 25 should be appended to the office or other outpatient service code to indicate that a significant, separately identifiable E/M service was provided by the same physician on the same day as the preventive medicine service.

The comprehensive nature of the preventive medicine service codes reflects an age- and gender-appropriate history and physical examination.

Immunizations and ancillary studies involving laboratory, radiology or other procedures, or screening tests (e.g., vision, developmental and hearing screening) identified with a specific CPT code (e.g. Z23 is Encounter for Immunization) are reported separately from the preventive medicine service code.

Preventive Medicine Service Codes

EPSDT exams and age recommended health screenings should be coded on claim forms using the codes indicated below:

Newborns
CPT codes:
99460 Initial care, hospital or birthing center, normal newborn
99461 Initial care, hospital or birthing center, normal newborn
99463 Initial care, hospital or birthing center, normal newborn (admission/discharge on same date)

Birth to Age 21 (end of 21st birth month)
CPT codes:
99381 through 99385
99391 through 99395

New Patients
The following CPT codes should be billed with an appropriate ICD-10 diagnostic code:

CPT Codes	ICD-10-CM Codes
99381 Infant (younger than 1 year)	Z00.110 Health supervision for newborn younger than 8 days old
	Z00.111 Health supervision for newborn 8 to 28 days old
	Z00.121 Routine child health exam with abnormal findings
	Z00.129 Routine child health exam without abnormal findings
99382 Early childhood (age 1 – 4)	Z00.121-Z00.129
99383 Late childhood (age 5 – 11)	Z00.121-Z00.129
99384 Adolescent (age 12 – 17)	Z00.00 General adult medical exam without abnormal findings
99385 18 years or older	Z00.01 General adult medical exam with abnormal findings

Established Patients
The following CPT codes should be billed with an appropriate ICD-10 diagnostic code:

CPT Codes	ICD-10-CM Codes
99391 Infant (younger than 1 year)	Z00.110 Health supervision for newborn younger than 8 days old
	Z00.111 Health supervision for newborn 8 to 28 days old
	Z00.121 Routine child health exam with abnormal findings
	Z00.129 Routine child health exam without abnormal findings
99392 Early childhood (age 1 – 4)	Z00.121-Z00.129
99393 Late childhood (age 5 – 11)	Z00.121-Z00.129
99394 Adolescent (age 12 – 17)	Z00.00 General adult medical exam without abnormal findings
	Z00.01 General adult medical exam with abnormal findings
99395 Transition Age Youth (age 18 and older)	Z00.00 General adult medical exam without abnormal findings
	Z00.01 General adult medical exam with abnormal findings

EPSDT Special Services

Under the EPSDT benefit, Medicaid provides comprehensive coverage for any service described in section 1905(a) of the Social Security Act. EPSDT special services include coverage for other medically necessary healthcare, evaluation, diagnostic services, preventive services, rehabilitative services and treatment or other measures not covered under Kentucky Medicaid:

- Special services may be preventive, diagnostic, treatment or rehabilitative services that are medically necessary to "correct or ameliorate" the individual's physical, developmental or behavioral condition.
- Medically necessary services are available regardless of whether those services are covered by Kentucky Medicaid.
- Medical necessity is determined on a case-by-case basis.
- EPSDT special services that are subject to medical necessity often require prior authorization.
- Consideration by the payer source must be given to the child's long-term needs, not only immediate needs and consider all aspects such as physical, developmental, behavioral, etc.

NOTE: KCHIP Phase III members are not eligible for emergency transportation or EPSDT special services.

EPSDT Referrals for Further Diagnosis and Treatment

If the PCP is unable to provide all components of the EPSDT exam or if screenings indicate the need for further 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. When deemed medically necessary and prior authorization is secured, an EPSDT member may receive care from an out-of-network provider.

High-risk Children

Children at high risk should be tested according to the 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 healthcare or presenting need.

EPSDT Care Management Services

Care management services are available as part of the EPSDT program to all members from birth through the end of their 21st birth month who have special healthcare needs. If you would like more information on the EPSDT program, please call Member Services at **1-855-852-7005**.

Blood-lead Level Risk Assessment and Testing

The Kentucky Medicaid Department for Public Health Childhood Lead Poisoning Prevention Program (CLPPP) requires that children receive a blood-lead level test at one and two years of age. This is a required part of the EPSDT exam provided at these ages.

Lead Screening Test Specifications

- Kentucky Medicaid requires healthcare providers to provide blood lead screening at 12 months and 24 months.
- Children 6 months to 6 years of age per the AAP: CMS requires each state to use a periodicity schedule to provide EPSDT services at age-recommended intervals that meet reasonable standards of medical practice. Kentucky uses the periodicity schedule published by the AAP and Bright Futures; 907 KAR 11:034.
- All children 72 months of age and younger and pregnant women who, per KRS 211.900:
  - Reside in dwellings or dwelling units which were constructed and painted prior to 1978
  - Reside in geographic areas defined by the cabinet as high risk
  - Possess one or more risk factors identified in a lead poisoning verbal risk assessment approved by the cabinet

Elevated Lead Levels

- Confirmed elevated blood lead level greater than 5µg/dL for a child younger than 72 months of age or a pregnant woman
  - Local health departments provide follow-up case management intervention per DPH.
  - Case management services include repeat testing, preventive education, referral to nutrition services, home visits to identify potential lead sources and education to minimize exposure.
- Confirmed blood lead level greater than 15µg/dL requires public health environmental action per KRS 211.905:
  - Refer to the local health department for comprehensive environmental lead home inspection/ risk assessment.
  - Identify child accessible lead hazard sources through sampling in and around any structure where the patient spends six or more hours a week.
  - Discuss preventive strategies with the family.

Reporting

- All labs in the state of Kentucky must report all blood-lead levels greater than and equal to 2.3µg/dL electronically to the Cabinet for Health and Family Services within seven days of any agency receiving these results per KRS 211.902.
- Use by providers of the point-of-care in-house portable lead analyzer, Lead Care II, establishes them as an in-house lab.
  Note: As the Lead Care II only reports results as low as 3.3µg/dL, all positive results are reportable.

Immunizations

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 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). This schedule is updated annually and the most current updates can be found on the AAP website at https://www.aap.org/.

Vaccines for Children Program

Providers may administer immunizations obtained through the Vaccines for Children (VFC) program to Humana – CareSource members. This program makes vaccines available to providers free of charge.

Members of the Kentucky Medicaid program who are 18 years of age or younger (from birth through age 18) 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 Kentucky Department for Public Health and the Kentucky Department for 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.

Eligibility

Children, birth through 18 who meet at least one of the following critieria are eligible for the VFC program:

- Enrolled in Medicaid
- Do not have insurance
- American Indian or Alaskan Native
- Have health insurance that does not cover vaccines or are underinsured
- Enrolled in the Kentucky Children's Health Insurance Program (KCHIP)

Underinsured children are eligible to receive VFC vaccines at federally-qualified health centers (FQHCs), rural health clinics (RHCs) or any local health department.

Provider Enrollment

Participating providers who administer vaccines must enroll in the VFC program through the Kentucky Cabinet for Health and Family Services (CHFS). To enroll, providers may contact the CHFS Immunization Program field staff representative for their area. A contact list of field staff representatives may be found at https://chfs.ky.gov/.

Reimbursement

Providers who participate in the VFC program must use the VFC vaccines for Humana – CareSource Medicaid insured members (birth through age 18). These vaccines are supplied to VFC program participants at no cost; therefore, there is no reimbursement for these vaccines. Humana – CareSource will reimburse participating providers an administration fee for VFC Medicaid-approved vaccines.

Providers not participating in the VFC program may use their private stock vaccines for their Medicaid members (birth through age 18). In this case, Humana – CareSource will reimburse the provider for the private stock vaccine and for an administrative fee.

For questions about this program, contact the Kentucky Immunization program at 1-502-564-4478.

Annual Wellness Exams for Adults

All adults are eligible to receive a wellness exam from a primary care provider (PCP) at the earliest opportunity on 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 Health Care Links webpage at **CareSource.com** > Providers > Education > Patient Care > Health Care Links, selecting Kentucky Medicaid, for up-to-date clinical and preventive care guidelines.

Behavioral Health & Substance-use Services

Behavioral health and substance-use services are covered services for Humana – CareSource members. Humana – CareSource is contracted with Beacon Health Options for the provision of these services. Beacon provides a comprehensive range of behavioral healthcare services for Humana – CareSource members, including:

- 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
- Access to community-based resources

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 engages in behavioral health promotion efforts, psychotropic medication management, suicide prevention and overall person-centered treatment approaches, to lower morbidity among members who have serious mental illness (SMI) and/or are seriously emotionally disturbed (SED), including members with co-occurring developmental disabilities, substance-use disorders and tobacco use.

In the design and operation of behavioral health services, Humana – CareSource upholds the following core values for Medicaid members:

- Members have the right to retain the fullest control possible over their behavior health treatment.
- Behavioral health services are responsive, coherently organized and accessible to those who require behavioral healthcare.
- Humana – CareSource provides the most normative care in the least restrictive setting and serve members in the community to the greatest extent possible.
- Humana – CareSource measures members' satisfaction with the services they receive.
- Humana – CareSource's behavioral health services are recovery- and resiliency-focused.

Screening & Evaluation

Humana – CareSource requires that primary care providers (PCPs) have screening and evaluation procedures in place for the detection and treatment of, or referral for, known or suspected behavioral health problems and disorders. PCPs may provide clinically appropriate behavioral health services within the scope of their practice.

Humana – CareSource provides training to network PCPs on how to screen for and identify behavioral health disorders, on Humana – CareSource's behavioral health services referral process and on clinical coordination requirements for such services. Humana – CareSource also includes coordination and quality of care training, such as behavioral health screening techniques for PCPs, and new models of behavioral health interventions. Training resources can be found on our website at **CareSource.com** > Providers > Tools & Resources > Quick Reference Materials, selecting Kentucky Medicaid from the menu.

Care Management

Humana – CareSource members have access to specialty behavioral healthcare managers for assistance in obtaining both routine and high-complexity healthcare services through our contracted vendor, Beacon. Humana – CareSource PCPs may contact Beacon for assistance in facilitating specialty behavioral health services for our members.

Beacon will assist members and PCPs with provider referrals and with making appointments for members in need of therapy and/or psychiatric services.

Coordination of Care

Humana – CareSource coordinates between behavioral health providers and PCPs. Humana – CareSource requires that behavioral health 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 healthcare services if they are licensed to do so.

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

Continuation of Treatment

Humana – CareSource requires all members receiving inpatient behavioral health services to schedule outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Humana – CareSource requests that behavioral health providers contact patients who have missed an appointment within 24 hours to reschedule appointments.

Pharmacy

Humana – CareSource pharmacy coverage includes retail prescription drugs, many of which are administered in the patient's home.

Prescribing providers are required to be Medicaid-enrolled providers. Medicaid providers who prescribe for Humana – CareSource members must contact us for medication prior authorizations. Access our Pharmacy webpage at **CareSource.com** > Providers > Education > Pharmacy, selecting Kentucky Medicaid from the menu, to locate prior authorization forms. For questions pertaining to pharmacy prior authorization requests, please contact us at **1-855-852-7005** or fax 866-930-0019.

Network Pharmacies

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 members. Members can access our "Find a Pharmacy" tool from any Kentucky Medicaid member webpage at CareSource.com/ky/members/medicaid/ in the Quick Links.

Copayment Requirements

Please check HealthNet to confirm copayments.

Medications Administered in the Provider Setting

Humana – CareSource covers medications that are administered in a provider setting, such as a physician office, hospital outpatient department, clinic, dialysis center or infusion center. Prior authorization requirements exist for many injectables.

Transition Period

Members transferring from one managed care organization (MCO) to another have a 30-day transition period. After the 30-day transition period ends, prior authorization may be applicable, depending on the member's medications. The transition period is not applicable for specialty pharmacy drugs, and prior authorization is required to verify continuing therapy.

To avoid disruption to a member's medications, it is important to quickly identify which drugs require prior authorization. Please check our Pharmacy webpage at **CareSource.com** > Providers > Education > Pharmacy, selecting Kentucky Medicaid from the menu, to identify medications that require prior authorization or call **1-855-852-7005** before the next refill.

Formulary

Humana – CareSource uses evidence-based guidelines to ensure healthcare services and medications meet the standards of excellent medical practice and are the lowest-cost alternative for the member. Humana – CareSource uses a Preferred Drug List (PDL) or formulary. Some drugs require prior authorization. The online formulary contains information about prior authorization, quantity limits, step- therapy protocols and therapeutic interchanges for most drug classes.

Access our Pharmacy webpage at **CareSource.com** > Providers > Education > Pharmacy, selecting Kentucky Medicaid from the menu, to locate both an online and a PDF version of our formulary.

Pharmaceutical Management Procedures

More information about how to use our pharmaceutical management procedures is available in the introduction of the formulary. If you have questions regarding our pharmaceutical management procedures, please call Humana – CareSource at **1-855-852-7005**.

Limits & Quotas

Some drugs have limits on how much can be given at one time. Quantity limits are based on patient safety and approved recommended dose frequencies.

Step Therapy, Therapeutic Interchange and Generic Substitutions

Certain drugs will be covered only if step-therapy criteria are met. Members may need to try one drug before taking another, or a medicine on the formulary must be tried before a nonformulary drug is approved by Humana – CareSource.

Through a process of generic substitution, a pharmacy will provide, if available, a generic drug in place of a branded drug. Members can expect the generic to produce the same effect and have the same safety profile as the branded drug. If a branded drug is requested when a generic equivalent is available, a prior-authorization request will need to be submitted. Additionally, if a member has a drug allergy or intolerance, or a certain drug might not be effective and a nonformulary agent is requested, referred to as a therapeutic interchange, a prior-authorization request would be required.

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 as effective as the drug you are requesting and would not cause more side effects or other health problems, we 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.

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 Grievances & Appeals section of this manual for details on how to submit appeals.

Tamper-resistant Prescriptions

In compliance with The Centers for Medicare & Medicaid Services, Kentucky Board of Pharmacy statutes, Regulations (902 KAR 55:105) and to prevent Medicaid prescription fraud, we ask prescribers and pharmacies to adhere to Kentucky Medicaid tamper-resistant prescription requirements on all hand-written and hard-copy prescriptions. Excluded from this requirement are faxed, electronic and phoned prescriptions.

To be considered "tamper resistant," prescriptions must contain one or more of the following industry-recognized features:

- Designed to prevent unauthorized copying of a completed or blank prescription form
- Designed to prevent erasure or modification of information written on the prescription by the prescriber
- Designed to prevent use of counterfeit prescription forms

Medicaid medications are reimbursable only if they include the following security features:

1. **Void pantograph** background screened at five percent in Pantone green shall be printed across the entire front of the prescription blank.
2. **Artificial watermark** placed on the backside of script so that it shall only be seen at a 45-degree angle. The watermark shall consist of the words "Kentucky Security Prescription," and appear horizontally in a step-and-repeated format in five lines on the back of the prescription using 12-point Helvetica bold type style.

3. **Opaque Rx symbol** shall appear in the upper right-hand corner, 1/8 of an inch from the top of the prescription blank and 5/16 of an inch from the right side of the prescription blank. The symbol shall be 3/4 of an inch in size and disappear if the prescription is lightened.
4. **Six quantity check off boxes** printed on the form and the following quantities shall appear and be marked:

☐ 1-24	☐ 50-74	☐ 101-150
☐ 25-49	☐ 75-100	☐ 151 and over

5. The following statement shall be printed on the bottom of the prescription blank: **Prescription is void if more than one prescription is written per blank.**
6. **Refill options** shall appear below any logo on the left side of the prescription blank in the following order: Refill NR 1, 2, 3, 4 and 5, and be marked if the prescribed drug is a schedule III, IV or V controlled substance.
7. **Size of the prescription blank** shall be 4 1/4 inches high and 5 1/2 inches wide.
8. A prescription shall bear the preprinted, stamped, typed or manually printed name, address and telephone number of the prescribing practitioner.
9. A prescription blank for a controlled substance shall provide space for the patient's name and address, the practitioner's signature and the practitioner's Drug Enforcement Administration (DEA) registration number.
10. A prescription blank for a controlled substance shall not contain:
    a. Advertisements on the front or back of the prescription blank
    b. The preprinted name of a controlled substance
    c. The written, typed or rubber-stamped name of a controlled substance until the prescription blank is signed, dated and issued to a patient

Reproductive Health Services

Humana – CareSource covers family planning services, abortions, hysterectomy and sterilizations in very limited circumstances. Please review the information below for specific information. Visit the Forms webpage at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Kentucky Medicaid from the menu, for the abortion, hysterectomy and sterilization forms.

Voluntary Family Planning

Voluntary family planning services are covered for eligible Humana – CareSource members. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning. For prior authorization requirements, please refer to the

Referrals & Prior Authorizations section. Please note the following guidelines for voluntary family planning services:

- No referral is required.
- Members may have family planning services provided by qualified family planning providers (e.g., Planned Parenthood) who are not participating in the Humana – CareSource network.
- Confidentiality shall be maintained for all members, including those younger than 18. All information shall be provided in a confidential manner.
- Appointments for counseling and medical services shall be available as soon as possible within a maximum of 30 days.
- If it is not possible to provide complete medical services to members younger than 18 on short notice, counseling and a medical appointment will be provided within 10 days by another participating provider or a qualified family planning provider.
- Family planning services and all necessary follow-up care is to be confidential, assuring privacy for all members, including adolescents (42 CFR § 59.11 and KRS § 214.185).

Abortion

Abortion services are covered for eligible Humana – CareSource members with prior authorization in cases of reported rape or incest and instances in which the woman suffers from a physical disorder, physical injury or physical illness, as certified by a physician, that would place the woman in danger of death if the fetus were carried to term.

Prior authorization is required for the administration of an abortion to validate medical necessity per federal and state regulations. Humana – CareSource will not cover any induced abortion or miscarriage performed out of compliance with federal and Kentucky laws and judicial opinions.

The physician performing the abortion must certify that the circumstances above have occurred by properly completing and executing the MAP 235 form. 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. You can access this form from the Forms webpage at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Kentucky Medicaid from the menu.

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

Sterilization

Sterilization procedures are covered if the following requirements are met:

- The member is at least 21 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 accessed from the Forms webpage at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Kentucky Medicaid from the menu, 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.

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 can be found on the Forms webpage at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Kentucky Medicaid from the menu. 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.

REFERRALS & PRIOR AUTHORIZATIONS

This section describes our utilization management functions, the referral and prior-authorization processes and requirements for services provided to Humana – CareSource members.

Referrals

Humana – CareSource facilitates direct access to specialized providers in the following circumstances:

1. Members with long-term, complex health conditions
2. Aged, blind, deaf or disabled persons
3. Members identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring.

Humana – CareSource members may see any participating provider within our network, including specialists and inpatient hospitals. Humana – CareSource does not require referrals from PCPs to see participating specialists. Members may self-refer to any participating provider. PCPs do not need to arrange or approve these services for members, as long as applicable benefit limits have not been exhausted.

Exceptions to this policy apply to members who have been designated to participate in the Kentucky Lock-in Program (KLIP). Please refer to the KLIP section of the manual on page 83.

Medicaid members may go to nonparticipating providers, without a referral, 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

All other nonparticipating providers are required to have a referral.

Making a Referral to Nonparticipating Provider

A referral is required for plan members to be evaluated or treated by nonparticipating specialists. Treating doctors can refer Humana – CareSource members to nonparticipating specialists who are enrolled in Kentucky Medicaid. All providers (referring, treating, nonparticipating) must be enrolled with the Kentucky Department for Medicaid Services as a Kentucky Medicaid Enrolled provider in order to receive payment for services rendered to a Kentucky Medicaid beneficiary. Please refer to pg. 106 for more information.

Referring Doctors

If you are a referring doctor, place a note about the referral in the patient's chart. You are not required to use a referral form or send a copy to our health plan. However, you must notify the nonparticipating specialist of your referral. If you have difficulty finding a specialist for your Humana – CareSource member, please call Provider Services at **1-855-852-7005**.

Referrals to Nonparticipating Providers

A member may be referred to a nonparticipating provider if the member needs medical care that only can be received from a doctor or other provider who is not participating with our health plan. Referring (treating) providers must get prior authorization from Humana – CareSource before sending a member to a nonparticipating provider (see the Prior Authorization section). All providers must be enrolled with the Kentucky Department for Medicaid. Services as a Kentucky Medicaid Enrolled provider in order to receive payment for services rendered to a Kentucky Medicaid beneficiary. Please refer to pg. 106 for more information.

Nonparticipating Specialists

If you are a nonparticipating 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. In general, 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. All providers must be enrolled with the Kentucky Department for Medicaid Services as a Kentucky Medicaid Enrolled provider in order to receive payment for services rendered to a Kentucky Medicaid beneficiary. Please refer to pg. 106 for more information.

Standing Referrals

A PCP may request a standing referral to a nonparticipating specialist for a member with a condition or disease that requires specialized medical care over a prolonged period of time. The nonparticipating 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. All providers must be enrolled with the Kentucky Department for Medicaid Services as a Kentucky Medicaid-enrolled provider in order to receive payment for services rendered to a Kentucky Medicaid beneficiary. Please refer to pg. 106 for more information.

Members who meet the definition of Children with Special Health Care Needs (CSHCN) may access nonparticipating 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 for Second Opinions for Nonparticipating Providers

A second opinion is not required for surgery or other medical services. However, providers or members may request a second opinion at equal 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 and a referral 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.

Referrals for Release Due to Ethical Reasons

Providers are not required to perform any treatment or procedure that is contrary to the provider's conscience, religious beliefs or ethical principals, in accordance with 42 C.F.R 438.102. Please refer to Involuntary Dismissal on pg. 10 for specific procedural requirements.

Referrals for Services Not Covered by Humana – CareSource

When it is necessary for a patient to receive a Medicaid service that is outside of the scope of the covered services provided by Humana – CareSource, the provider shall refer the member to a provider enrolled in the Kentucky Medicaid fee-for-service program. Please refer to the Covered Services section of the manual found on pg. 23.

Prior Authorization

Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations.

When 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.

Authorization is not a guarantee of payment. Authorization is based on medical necessity and is 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 provider not following the requirements listed in this manual.

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
- Cosmetic procedures and plastic surgery
- Food supplements/nutritional supplements (more than 30 cans or 72 units per month require prior authorization)
- Genetic testing
- Greater than 10 fetal nonstress tests per pregnancy
- Home care services and therapies including private-duty nursing
- Hospice services (inpatient, continuous care and respite care require prior authorization; routine home hospice care does not require prior authorization)
- Inpatient rehabilitative services
- Non-emergent transportation (except facility-to-facility transfers)
- Nursing facility services
- Organ/tissue/bone transplants
- Orthodontia treatment and other dental services
- Pain management
- Prescribed pediatric extended care (PPEC) services
- Select durable medical equipment, regardless of amount, specifically:
  - All powered or customized wheelchairs
  - Manual wheelchair rentals longer than three months
  - All miscellaneous codes (e.g., E1399)
  - Hearing aids
- Durable medical equipment (excluding the above items) and other supplies with billed charges greater than $750
- Services beyond benefit limits for members younger than 20

Requesting Prior Authorization

This section describes how to request prior authorization for medical and radiology services. For pharmacy prior authorization information, refer to the Pharmacy section of this manual.

Medical

Prior authorization for healthcare services can be obtained by contacting the Utilization Management department online or via email, fax, phone or mail:

- Visit the Provider Portal at **CareSource.com** > Login > Provider, selecting Kentucky from the menu.
- Access various prior authorization forms online at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Kentucky Medicaid from the menu.
- Email completed forms to kymedicalmanagement@caresource.com.
- Fax completed prior authorization forms to 1-888-246-7043.
- Call **1-855-852-7005** and follow the menu prompts for authorization requests, depending on your need.
- Mail completed forms to:
  Humana – CareSource
  Attn: Kentucky Utilization Management
  P.O. Box 8738
  Dayton, OH 45401

When requesting authorization, please provide the following information:

- Member/patient name and Humana – CareSource member ID number
- Provider name, National Provider Identifier (NPI) and tax ID number (TIN) for ordering/servicing providers and facilities
- 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.

Radiology Services

Humana – CareSource partners with HealthHelp to provide consultation of 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.

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 90 calendar days from the date of service or the inpatient discharge date, or within 90 calendar 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 calendar days from the date of the service, 180 calendar days from the inpatient discharge date or within 180 calendar 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 calendar days from the date of service or the inpatient discharge date, or within 90 calendar days of the date of the adverse decision letter.

A request for retrospective review can be made by calling the Utilization Management department at **1-855-852-7005** and following the appropriate menu prompts. You may also fax the request to 1-888-527-0016. Clinical information supporting the service must accompany the request.

Utilization Management (UM)

UM helps maintain the quality and appropriateness of healthcare services provided to Humana – CareSource members. Utilization review determinations are based only on appropriateness of care and service and existence of coverage. Humana – CareSource does not reward providers or our staff for denying coverage or services. There are no financial incentives for the staff of Humana – CareSource to encourage decisions that result in underutilization. Humana – CareSource does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition. Humana – CareSource establishes measures designed to maintain quality of services and control costs that are consistent with our responsibility to our members; we place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan, and applicable regulations, such as medical necessity; and place appropriate limits on a service for utilization control, provided the service furnished can reasonably be expected

to achieve its purpose. Services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports.

The Utilization 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 Care Management team are made, if needed.

Providers can find or receive Humana – CareSource's UM criteria by submitting a request via the following methods:

- Phone: **1-855-852-7005**
- Fax: 1-888-246-7043
- 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. These criteria are designed to assist 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 policy statements developed to supplement nationally recognized criteria. You can access these policies from the policy landing page at **CareSource.com** > Providers > Tools & Resources > Provider Policies, selecting Kentucky Medicaid from the menu.

If a patient's clinical information does not meet the criteria, the case is forwarded to a Medical Director for further review and determination.

Access to Staff

Providers may call our toll-free number, **1-855-852-7005**, to contact Utilization Management staff with any UM questions.

- Staff are available from 8 a.m. to 6 p.m. Eastern time, Monday through Friday, for inbound calls regarding UM issues.
- Staff can receive inbound communication regarding UM issues after normal business hours. Providers may leave voice mail messages after business hours, 24 hours a day, seven days a week. A dedicated fax line, email address and the provider portal can be used for medical necessity determination requests 24 hours a day, seven days a week.
- 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.
- In the best interest of our members and to promote positive healthcare outcomes, Humana – CareSource supports and encourages continuity of care and coordination of care between medical providers as well as between behavioral health providers.

Physician reviewers from Humana – CareSource are available to discuss individual cases with attending physicians upon request. Criteria also are available upon request by contacting our Utilization 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 providers or our staff for denying coverage or services. There are no financial incentives for the staff of Humana – CareSource to encourage decisions that result in underutilization. Humana – CareSource does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition.

Our members' health is always our number one priority. On request, Humana – CareSource provides the clinical rationale or criteria used in making medical necessity determinations. You may request the information by calling or faxing the Humana – CareSource Utilization Management department. If you would like to discuss an adverse decision with a Humana – CareSource physician reviewer, please call the Utilization Management department at **1-855-852-7005, ext. 5143**, within five business days of the determination.

CLAIMS

Humana – CareSource follows the claim 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.

Please note: Providers need to submit paper and electronic claims with ICD-10 codes as of Oct. 1, 2015. Failure to include ICD-10 codes on claims filed on or after Oct. 1, 2015, will result in claim denial.

Claim Submissions

Claims must be submitted within 180 calendar 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 180 calendar days from the date of service or discharge to submit a corrected claim or file a claim appeal.

Humana – CareSource accepts electronic and paper claims. We encourage you 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

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-10 diagnosis code(s).
- HIPAA-compliant Common Procedural Terminology (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 the corresponding prior authorization information. This is only needed if the service provided required a prior authorization.
- National Provider Identifier (NPI): Please refer to the Location of Provider NPI, TIN and Member ID Number section.
- 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 Master Provider List (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.

Electronic Funds Transfer

Humana – CareSource offers electronic funds transfer (EFT) as a payment option. Visit our Claims webpage at **CareSource.com** > Providers > Provider Portal > Claims, selecting Kentucky Medicaid from the menu, for additional information about getting paid electronically and enrolling in EFT.

Simply complete the enrollment form 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.

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 at **CareSource.com** > Login > Provider, selecting Kentucky from the menu, or receive a hard copy via mail.

Benefits of EFT include:

- Simplicity — 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. Free EFT training is also available to Humana – CareSource providers through InstaMed during the enrollment process.
- 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.

Electronic Claim Submissions

You can submit claims online through our secure provider portal at **CareSource.com** > Login > Provider, selecting Kentucky from the menu. Humana – CareSource offers this service via our portal at no cost. You can submit claims, check claim status, track payments and more.

Humana – CareSource also partners with Availity to offer electronic claim submission and real-time transactions at no charge through the Availity Portal at www.availity.com/. You can use the Availity Portal Registration Guide at **CareSource.com** > Providers > Provider Portal > Claims, selecting Kentucky Medicaid from the menu, to sign up.

Humana – CareSource contracts with Beacon Health Options to provide behavioral health services. Behavioral health claims must be submitted to Beacon. For more information and access to resources from Beacon, visit our Behavioral Health webpage at **CareSource.com** > Providers > Education > Behavioral Health, selecting Kentucky Medicaid from the menu.

EDI Clearinghouses

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 claim submission.

To submit claims electronically, providers must work with an electronic claim 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 claim submission.

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

Clearinghouse	Phone	Website
Change Healthcare (Emdeon)	1-800-845-6592	www.changehealthcare.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

5010 Transactions

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic healthcare 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

Procedure and Diagnosis Codes

HIPAA specifies that the healthcare industry use the following four code sets when submitting healthcare claims electronically:

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-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, available at www.ama-assn.org/practice-management/cpt-current-procedural-terminology
- HCFA Common Procedure Coding system (HCPCS), available at 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 www.fda.gov/

Please note: 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 providers and health plan organizations. Local or proprietary codes are no longer allowed.

Unlisted CPT/HCPCS Codes

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.

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 (e.g., 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.

Effective Oct.1, 2013, Kentucky Department for Medicaid Services (KDMS) requires 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.

Effective Aug. 1, 2018, the Kentucky Department for Medicaid Services (KDMS) updated billing provider taxonomy claim requirements for the following provider types:

- Federally qualified health centers, provider type 31 with a specialty code 080
- Rural health centers, provider type 35

If billing providers have only one taxonomy linked to their KDMS master provider list (MPL) National Provider Identifier (NPI), then their claims do not need to include taxonomy (refer to Appendix - Claim Taxonomy Examples). Taxonomy is still required for the following:

- Billing providers who have multiple taxonomies linked to their NPI on the KDMS MPL
- All rendering providers

If your NPI and taxonomy codes change, please ensure you update your taxonomy information with Humana – CareSource and the commonwealth's MPL. Use the Request to Update NPI and/or Taxonomy Code form located on our Forms webpage at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Kentucky Medicaid from the menu.

Location of Provider NPI, TIN and Member ID Number

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

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 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:

- 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 tax ID number (TIN) must be submitted as the secondary provider identifier using a REF segment, which is either the EIN for organizations or the SSN for individuals:

- 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 Claim Submissions

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 forms:

- 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).

Detailed instructions for completing forms are available at the following websites:

- CMS-1500 Form Instructions: www.nucc.org
- UB-04 Form Instructions: www.cms.hhs.gov/transmittals/downloads/R1104CP.pdf

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

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

Humana – CareSource uses optical/intelligent character recognition (OCR/ICR) systems to capture claims information to increase efficiency and to improve accuracy and turnaround time. We cannot accept handwritten claims or super bills.

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 providers and health plan organizations. Local or proprietary codes are no longer allowed.

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), the 11-digit NDC (this excludes the N4 qualifier), a unit of measurement code (F2, GR, ML or UN are the only acceptable codes) and 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 and the units on paper forms.

Tips for Submitting Paper Claims

- Electronic claims are generally processed more quickly than paper claims.
- If you submit paper claims, we require the most current form version as designated by CMS, National Uniform Claim Committee (NUCC) and the ADA.
- No handwritten claims or super bills, including printed claims with handwritten information, 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 claim submissions.
- All data must be updated and on file with the KDMS MPL, including TIN, billing and rendering NPI, addresses and taxonomy codes.
- Coordination of Benefits (COB) paper claims require a copy of the Explanation of Payment (EOP) from the primary carrier.

Out-of-Network Claims

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 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

Claim Processing Guidelines

- Providers have 180 calendar days from the date of service or discharge to submit a claim. If the claim is submitted after 180 calendar 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 180 calendar days of the original date of service.
- If a provider does not agree with the decision on a processed claim, he or she has 180 calendar 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.
- COB electronic claims require a copy of the primary carrier's payment information.
- If a claim is denied for COB information needed, the provider must submit the primary payer's 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 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 birth weight.
- 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.
- 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.
- 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.

Claim Status

You can track the progress of submitted claims at any time through our provider portal at **CareSource.com** > Login > Provider, selecting Kentucky from the menu. Claim status is updated daily and provides information on claims submitted in the previous 24 months. Searches by member ID number, member name and date of birth or claim number are available.

You can find the following claim information on the provider portal:

- Reason for payment or denial
- Check number(s) and date
- Procedure/diagnostic
- Claim payment date

Explanation of Payment (EOP)

EOPs are current claim status statements submitted to Humana – CareSource and entered into our system. EOPs are generated weekly. However, providers may not receive an EOP weekly, 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.

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.

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 provider. Humana – CareSource clinical editing software helps evaluate the accuracy of the procedure code only, not the medical necessity of the procedure.

Coding and Payment Policies

Humana – CareSource strives to be consistent with KDMS, Medicaid 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 electronically or as a hard copy.

We apply HIPAA standards to all electronically received claims. Accordingly, we accept only HIPAA-compliant code sets (i.e., HCPCS, CPT, and ICD-10).

In addition, the Centers 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 visit chfs.ky.gov/agencies/dms/Pages/feesrates.aspx.

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 takes into consideration the previously mentioned commonwealth, Medicaid, 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 that overrides the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Specific claims are subject to current Humana – CareSource claim logic and other established coding benchmarks. 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.

Coordination of Benefits (COB)

Humana – CareSource collects COB information for our members. This information helps us ensure that we pay claims appropriately and coply 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 updated periodically, and some updates may not always be fully reflected on our Provider Portal. Please ask Humana – CareSource members for all healthcare insurance information at the time of service.

You can search for COB information 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 is received, indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full (i.e., $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 an 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 following address:

Humana – CareSource
P.O. Box 824
Dayton, OH 45401-0824

Providers should not refund money paid to a member by a third party.

Member Billing

Providers should bill and collect copayments as copayment amounts are subtracted from claim payments for services.

Covered Services

State requirements and federal regulations prohibit providers from billing Humana – CareSource members for medically necessary covered services except under very limited circumstances. Providers who knowingly and willfully bill a member for a Medicaid-covered service shall be guilty of a felony and upon conviction shall be fined, imprisoned or both, as defined in the Social Security Act.

Humana – CareSource monitors this billing policy activity based on complaints of billing from members. We implement a stepped approach when working with our providers to resolve member billing issues. Failure to comply with regulations after intervention may result in both criminal charges and termination of your agreement with Humana – CareSource.

Please remember that government regulations stipulate that providers must hold members harmless in the event that Humana – CareSource does not pay for a covered service performed by the provider. Members cannot be billed for services that are administratively denied. The only exception is if a Humana – CareSource member agrees in advance, in writing to pay for a non-Medicaid covered service. This agreement must be completed prior to providing the service and the member must sign and date the agreement acknowledging his or her financial responsibility. The form or type of agreement must specifically state the services or procedures that are not covered by Medicaid.

Providers should call Provider Services at **1-855-852-7005** for guidance before billing members for services.

Missed Appointments

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 healthcare 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 Care Management Support Services at **1-866-206-0272**.

Member Termination Claim Processing

From Humana – CareSource to Another Plan

In the event of a member's termination of enrollment with Humana – CareSource into a different Medicaid plan, Humana – CareSource may submit voided encounters to KDMS and notify providers of adjusted claims using the following process:

1. On daily receipt of the 834 eligibility file from the Kentucky Department for Medicaid Services (KDMS), Humana – CareSource will identify which members have received a retro-eligibility date and require termination of enrollment within the Humana – CareSource claims payment system.

2. Humana – CareSource will initiate the member termination process. This will be completed within five business days of receipt of the 834 file.
3. Humana – CareSource will determine whether claims were paid for dates of service in which the member was afterward identified as ineligible for Medicaid benefits with Humana – CareSource. This process will be completed within five business days.
4. Humana – CareSource will send out a notice to each affected provider that recoupment of payment will occur for the claim(s) identified in the recoupment letter. The provider will be given 30 calendar days to respond to the notice.
5. Once the 30 days has expired, if the affected provider has not attempted to appeal the recoupment of payment or has not submitted a refund check before 30 calendar days have expired, Humana – CareSource will adjust the payment(s) for the affected claims listed in the notice letter. This will take place within 10 business days.
6. The provider will receive an EOP reflecting the funds recouped. This will take place within five business days of completion of payment adjustment(s).
7. After the recoupment has received a processed date stamp, a voided encounter for the affected claims will be submitted to KDMS within ten business days, assuming the original submitted encounter was previously accepted. Please note that if the original encounter was denied or rejected by KDMS, a void does not need to occur.
8. Upon successful completion of the encounter-void process, affected providers will be sent a courtesy letter informing them that the original payment was successfully cleared from the KDMS system and that they can proceed in billing the claim(s) with the member's current active Medicaid plan. This will happen within five business days. Please note that if the commonwealth did not accept the voided encounter, the process may be delayed an additional ten business days.

If the provider experiences continued issues receiving payment from another Medicaid plan within 60 days of the issued EOP reflecting recoupment of payments and the issued courtesy letter, Humana – CareSource encourages providers to contact the member's current Medicaid Managed Care Plan for the claim(s) dates of service.

From Another Plan to Humana – CareSource

If a member was previously enrolled with another Medicaid plan and is now eligible with Humana – CareSource, providers are required to submit a copy of the EOP reflecting recoupment of payment and documentation from the previous managed care organization (MCO) to validate the original encounter has been voided and accepted by KDMS.

These items will be used to support overriding timely filing, if eligible. If a claim has exceeded timely filing due to retro-eligibility from another Medicaid plan, the provider has 90 days from the date of the accepted voided encounter to submit the claim to Humana – CareSource to avoid timely filing denials.

GRIEVANCES & APPEALS

A grievance is a complaint. An appeal is a request to change a previous decision made by Humana – CareSource.

As a provider, you can file grievances and appeals on your own behalf. You can file an appeal on behalf of a member if you have the member's written consent.

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.

Provider Grievances & Appeals

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 180 calendar days from the date of service or discharge to file an appeal. Effective Jan. 4, 2019, if a provider does not agree with the decision on a processed claim, the provider has 180 calendar days from the date of the **original claim submission denial** 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 the appeal is denied, you will be notified in writing. If the appeal is approved, payment will show on your EOP.

Humana – CareSource resolves provider grievances and appeals 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 a 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 180 calendar days from the date of service or discharge to submit a corrected claim.

Submissions

Grievances and appeals can be submitted through our secure provider portal, by fax or by mail.

Provider portal: **CareSource.com** > Login > Provider, selecting Kentucky from the menu
Fax: 1-855-262-9793
Mail: Humana – CareSource
Attn: Provider Appeals — Clinical
P.O. Box 823
Dayton, OH 45401

You can find KDMS-approved grievance and claim appeal forms from the following sources:

- Our Forms webpage at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Kentucky Medicaid from the menu
- Appendix I of this manual

External Independent Reviews

Humana – CareSource will comply with all rights and requirements conferred to providers, pursuant to 907 KAR 17:035.

- After a provider has exhausted all internal appeal rights, the provider can request an external independent review. A provider cannot request an external independent review if the member has exercised his/her right for a state hearing.

- The provider must submit a request for external independent review within 60 calendar days of receiving final decision on the internal appeal.
- After Humana – CareSource receives a request from a provider for external independent review, Humana – CareSource sends the provider an acknowledgement letter within five business days. Humana – CareSource also will send an acknowledgement letter to the member if the request involves an authorization denial.
- Humana – CareSource will submit all related documentation to the external review entity within 15 business days of receiving the request.
- The external independent review entity will issue a final decision with 30 calendar days of receiving the review packet from Humana – CareSource.
- Humana – CareSource and the provider both have the right to appeal the decision of the external independent review entity to a state hearing proceeding. The request for a state hearing must be sent to the state within 30 calendar days of the external independent review entity's decision.

Member Grievances, Appeals & Fair Hearing Requests

Members have the right to file a grievance or appeal. They also have the right to request a state hearing after they have exhausted their appeal rights.

Members are encouraged to call or write to us to let us know of complaints regarding Humana – CareSource or the healthcare services they receive. As a Humana – CareSource provider, we may contact you to obtain documentation when a member files a grievance or appeal or requests a state hearing. State and federal agencies require Humana – CareSource to comply with all requirements, including aggressive resolution timeframes.

Members or their 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.

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 after receipt of the grievance to notify the member that the grievance has been received and the date when resolution of the grievance is expected. An investigation and final resolution of a grievance will be completed within 30 days of the date the grievance is received by Humana – CareSource.

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 Humana – CareSource to provide services in a timely manner, as defined by the department or its designee
- The failure of Humana – CareSource to complete the authorization request in a timely manner as defined in 42 CFR 438.408
- 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. Within five working days of receipt of an appeal, Humana – CareSource will 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 the date 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 not exceed 14 days. Expedited appeals are resolved within 72 hours (three business days) 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.

State Fair Hearings

After members exhaust 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 120 days after 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 Kentucky Department for Medicaid Services (KDMS). 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 Street, 6C-C
Frankfort, KY 40621
Fax number: 1-502-564-6917

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

Submissions

Member grievances and appeals can be submitted by contacting Member Services at **1-855-852-7005**, or by fax or mail.

Fax: 1-855-262-9794
Mail: Humana – CareSource
Attn: Grievance & Appeals Specialist
P.O. Box 1947
Dayton, OH 45401

PROVIDER ROLES & RESPONSIBILITIES

Provider 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 healthcare insurance. Please reference the Member Rights & Responsibilities section of this manual.

Humana – CareSource expects participating providers to verify member eligibility and ask for all his or her healthcare insurance information before rendering services, except in an emergency. You can verify member eligibility on HealthNet and obtain information for other healthcare insurance coverage we have on file by accessing the Provider Portal at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Kentucky Medicaid from the menu.

Provider Status Changes

Advance written notice of status changes, such as a change in address, phone or adding or deleting a provider at your practice helps us keep our records current. 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.

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

Primary Care Providers (PCPs)

All Humana – CareSource members choose or are assigned to a PCP on enrollment in the plan. PCPs help facilitate a "medical home" for members. This means that PCPs help coordinate healthcare for the member and provide additional health options to the member for self-care or care from community partners. PCPs also are required to know how to screen and refer members for behavioral health conditions. Please refer to the Behavioral Health & Substance Use Services section for more information.

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.

Education

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

Roles and Responsibilities

Primary care providers shall:

- Be responsible for supervising, coordinating and providing initial and primary care to members
- Be responsible for initiating referrals for specialty care
- Be responsible for maintaining the continuity of patient care 24 hours per day, seven days a week
- 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 healthcare for our members by providing:

- Availability of a personal healthcare practitioner to assist with coordinating a member's overall care, as appropriate for the member
- Continuity of the member's total healthcare
- Early detection and preventive healthcare 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 –including high standards of care and the same hours of operation
- Maintaining continuity of the member's healthcare
- 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 a Humana – CareSource-covered 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 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 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for persons under the age of 21
- Recommending referrals to specialists, as required
- Participating in the development of care management care treatment plans and notifying Humana – CareSource of members who may benefit from care management
- Maintaining formalized relationships with other PCPs to refer their members for after-hours care, during certain days, for certain services or other reasons to extend their practices

Participating providers must meet the following Kentucky Medicaid contractual requirements related to acceptable after-hours access:

Acceptable:

- Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner, and the PCP or designee is available to return the call within a maximum of 30 minutes.
- Office phone is answered after hours by a recording directing the member to call another number to reach the PCP or another medical practitioner whom the provider has designated to return the call within a maximum of 30 minutes.
- Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of 30 minutes.

Unacceptable:

- Office phone is only answered during office hours.
- Office phone is answered after hours by a recording that tells patients to leave a message.
- Office phone is answered after hours by a recording that directs patients to go to the emergency room for services needed.
- After-hours calls are not returning within 30 minutes.

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 relationship with you and enable us to meet or exceed our commitment to improve the healthcare and well-being of our members. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of our members. Unless otherwise specified in a provider's contract, the following standard key contract terms apply: 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.
- Sending the required 60-day notice 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.
- Providing 24-hour availability to your Humana – CareSource-covered patients by telephone (for PCPs only). Whether through an answering machine or a taped message used after hours, patients should be provided 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.
- Submitting claims and corrected claims within 180 calendar days of the date of service or discharge.
- Filing appeals within 180 calendar 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 requests to reverse a Humana – CareSource determination regarding claim payment. Our appeal process is outlined in the Grievances & Appeals section of this manual.
- Offering a 24-hour nurse triage phone 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.

Member Rights & 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:

- To receive all services that Humana – CareSource must provide and to receive them in a timely manner without communication or physical access barriers
- To choose a provider who gives them care whenever possible and appropriate
- To choose a primary care provider (PCP) and to change their PCP to another PCP in Humana – CareSource's network. When members make PCP changes, Humana – CareSource sends them written confirmation of their new PCP.
- To obtain a second opinion from a qualified provider in Humana – CareSource's network. If a qualified provider is not able to see the member, Humana – CareSource must set up a visit with a provider not in the network.
- To timely referrals and access to medically indicated specialty care
- To be given information about their health: This information may also be available to someone the member has legally approved to have the information or who the member has indicated should be reached in an emergency when it is not in the best interest of the member's health to provide it.
- To ask questions and receive complete information relating to their medical condition and treatment options in a way that they can understand: This includes information regarding specialty care.
- To discuss information on appropriate or medically necessary treatment options for their condition regardless of cost or benefit coverage
- To take part in decisions about their healthcare unless it is not in the member's best interest.
- To say no to treatment or therapy: If the member says no, the doctor or Humana – CareSource must talk to the member about what could happen, and the provider must put a note in the member's medical record about it.
- To be treated with respect, dignity, privacy, confidentiality and nondiscrimination

- To consent to or refuse treatment or active participation in decision choices
- To be sure others cannot hear or see them when they are receiving medical care
- 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
- If an American Indian, to receive services from a participating Indian Health Service, tribally operated facility/program and Urban Indian Clinic (I/T/U) or I/T/U primary care provider
- To prepare advance medical directives pursuant to KRS 311.621 to KRS 311.643
- To receive assistance with medical records in accordance with applicable federal and state laws
- To be sure that their medical record information is kept private
- 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.
- To be able to say yes or no to having any information about them given out, unless Humana – CareSource has to provide it by law.
- To receive all Humana – CareSource written member information from us:
  - at no cost to them
  - in the prevalent non-English languages of members in the Humana – CareSource service area;
  - in other ways, to help with the special needs of members who may have trouble reading the information.
- To receive help free of charge from Humana – CareSource and our providers if they do not speak English or need help understanding information
- To receive help with sign language if they are hearing impaired
- To be told if the provider is a student and to be able to refuse his/her care
- To be told of any experimental care and to be able to refuse to be part of the care
- To know that Humana – CareSource must follow all federal and state laws and other laws about privacy that apply
- If a female, to be able to go to a woman's provider in Humana – CareSource's network for covered woman's health services
- To receive access to the grievance process and have a channel to voice grievances about Humana – CareSource or the care received, and to obtain assistance filing an appeal and requesting a state fair hearing from Humana – CareSource and/or the Department of Medicaid Services
- To prepare advance medical directives including living wills or durable powers of attorney for healthcare

- 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
  Phone: 1-800-368-1019
  Fax: 1-404-562-7881
  TDD: 1-800-537-7697
- To receive information about Humana – CareSource, our services, our practitioners and providers and member rights and responsibilities
- To make recommendations regarding Humana – CareSource's member rights and responsibilities policy
- To be free to carry out their rights and know that Humana – CareSource or our providers will not hold this against them

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.

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

- To become informed about member rights
- To abide by Humana – CareSource's and the Department of Community-Based Services' policies and procedures
- To become informed about service and treatment options
- To actively participate in personal health and care decisions and practice healthy lifestyles
- To understand as much as possible about their health issues and to take part in reaching goals that the member and the provider agree upon
- To report suspected fraud and abuse
- To use only approved providers
- To keep scheduled doctor appointments and be on time
- To follow the advice and instructions for care they have agreed on with their doctors and other providers

- To always carry their member ID card and present it when receiving services
- To never let anyone else use their Humana – CareSource ID card
- To notify Humana – CareSource and the Department of Community-Based Services of changes to their phone numbers or addresses
- To contact their PCPs after going to an urgent care center or after receiving medical care outside of Humana – CareSource's covered counties or service area
- To let Humana – CareSource and the Department of Community-Based Services know if they have other health insurance coverage
- To provide the information that Humana – CareSource and their providers need in order to provide care for them

Personally Identifiable Information and Protected Health Information

In the day-to-day business of patient treatment, payment and healthcare operations, Humana – CareSource and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide how PII is appropriately protected when stored, processed and transferred in the course of conducting normal business. As a 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 protected 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

Member Privacy

The HIPAA Privacy Rule requires health plans and covered healthcare practitioners to develop and distribute a notice that provides a clear, user-friendly explanation of individuals' rights with respect to their personal health information, as well as the privacy practices of health insurance plans and healthcare practitioners.

KDMS provides a privacy notice to Medicaid members. Access the HIPAA Information page at http://www.kymmis.com/kymmis/HIPAA/. The notice informs members about how KDMS is legally required to protect the privacy of member data.

As a provider, please follow the HIPAA regulations and make only reasonable and appropriate uses and disclosures of protected health information for treatment, payment and healthcare operations.

Member Consent to Share Health Information

Consent is the member's written permission to share their information. Not all disclosures require the member's permission. The following are consent requirements that pertain to Sensitive Health Information (SHI) and Substance-use Disorder (SUD) treatment:

- SHI is defined by the state (e.g., HIV/AIDS, mental health, sexually transmitted diseases).
- SUD 42 CFR Part 2 (Part 2), at www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr2_main_02.tpl, pertains to federal requirements that apply to all states.

While all member data is protected under the HIPAA Privacy Rules, Part 2 provides more stringent federal protections in an attempt to protect individuals with substance-use disorders who could be subject to discrimination and legal consequences in the event their information is inappropriately used or disclosed. The state requirements provide more stringent protections for the sharing of certain information determined to be SHI.

In an effort to help you efficiently coordinate care for our members, Humana – CareSource automated the Consent for Provider to File an Appeal on Patient/Member's Behalf Form available on our Forms page at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Kentucky Medicaid from the menu.

When consent is on record, Humana – CareSource will display all member information on the provider portal at **CareSource.com** > Login > Provider, selecting Kentucky from the menu, and any health information exchanges. Please explain to your patients that if they do not consent to let Humana – CareSource share this information, the providers involved in their care may not be able to effectively coordinate their care. When a member does not consent to share this information, a message displays on the provider portal to indicate that all of the member's health information may not be available to all providers.

The Member Consent/HIPAA Authorization Form also can be used to designate a person to speak on the member's behalf. This designated representative can be a physician, an attorney, a relative or some other person that the member specifies.

Cultural Considerations & 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.

Providers should promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity.

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 of 1990 and the Rehabilitation Act of 1973.

Humana – CareSource recognizes cultural differences and the influence that race, ethnicity, language and socioeconomic status have on the healthcare 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 healthcare. Unequal treatment found racial differences in the type of care delivered across a wide range of healthcare 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 healthcare 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 healthcare 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 language 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.

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 healthcare 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 for healthcare providers, with more detailed information available at www.cdihp.org.

Q. Which 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 healthcare providers covered by the Title III of the ADA. Title III applies to all private healthcare providers, regardless of size. It applies to providers of both physical and mental healthcare. 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 healthcare facilities that are operated by state or local governments are covered by Title II of the ADA. Healthcare providers that offer training sessions, health education or conferences to the general 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 healthcare 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 provider determine which auxiliary aid or service is best for a patient?

A. The 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 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 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 (e.g., 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 provider is not in compliance with the ADA?

A. If a 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.

Kentucky Lock-in Program (KLIP)

KLIP is a program designed for individuals enrolled in Medicaid in Kentucky who need help managing their healthcare 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 provider (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, a utilization review is conducted to determine the member's continued need for the program.

Provider Responsibilities

Primary care providers with KLIP members shall do the following:

- Provide services and manage the KLIP member's necessary healthcare needs.
- Complete and forward the Kentucky Lock-in Provider Referral 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. This form is available on our Forms webpage at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Kentucky Medicaid from the menu.
- 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 do the following:

- Receive and sign the Kentucky Lock-in Provider Referral Form, completed by the PCP and delivered by the member.
- Submit the signed Kentucky Lock-in Provider Referral Form with the claim.

Referrals

Humana – CareSource will monitor members' claim history and utilization to identify members who may benefit from enrollment in the Lock-in program. Members may also be referred for evaluation to participate in the Lock-in program by their primary care provider or a specialist who is caring for them. 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 younger than 18
- Receive services through a home- and community-based waiver program or hospice services
- Utilize Medicaid services at a frequency that was medically necessary to treat a complex, life-threatening medical condition

For more information or questions about the Kentucky Lock-in program, contact Humana – CareSource provider services at **1-855-852-7005**.

Emergency Department Diversion Program

Humana – CareSource is committed to making sure our members access appropriate healthcare services at the appropriate time for their needs. 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 emergency room (ER).

Members are advised to call 911 or go to the nearest ER if they feel they have an emergency. Humana – CareSource covers all emergency services for our members and educates members on the appropriate use of urgent care facilities.

Member ER utilization is tracked closely. If there is frequent ER utilization, members are referred to our care management team for analysis or intervention.

It is our goal 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 our members with accessing the most appropriate healthcare resources before an emergency arises. We appreciate your cooperation in educating your patients on the appropriate utilization of emergency services.

Emergency care will not be denied; however, if admitted, inpatient stays require prior authorization. The facility must notify Humana – CareSource as soon as possible and no later than 24 hours after an emergency admission and/or learning that the member is covered by the health plan.

Advance Directives

PCPs have the responsibility to discuss advance medical directives with adult members who are 18 or older and who are of sound mind at the first medical appointment. The discussion should subsequently be charted 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 other 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.

Physicians must prepare, maintain and retain as confidential the health records of all members receiving healthcare 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.

Complete medical records include, but are not limited to, medical charts, applicable directives, prescription files, hospital records, provider specialist reports, consultant and other healthcare 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:

- Member/patient identification information on each page
- 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
- Date of data entry and date of encounter
- Provider identification by name
- Allergies, adverse reactions and known allergies noted in a prominent location
- Past medical history, including serious accidents, operations and illnesses (for children, past medical history includes prenatal care and birth information, operations and childhood illnesses [e.g., documentation of chickenpox])
- Identification of current problems
- Consultation, laboratory and radiology reports in the medical record contain the ordering provider's initials or other documentation indicating review
- Documentation of immunizations pursuant to 902 KAR 2:060
- Identification and history of nicotine, alcohol use or substance abuse
- Documentation of reportable diseases and conditions submitted to the local health department serving the jurisdiction in which the patient resides or the Department for Public Health pursuant to 902 KAR 2:020

- Follow-up visits provided and secondary reports of emergency room care
- Hospital discharge summaries
- Advanced medical directives, for adults
- All written denials of service and the reason for the denial
- 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:

- 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
- Unresolved problems, referrals and results from diagnostic tests, including results and/or status of preventive screening services (e.g., EPSDT) addressed from previous visits
- Plan of treatment, including:
  - Medication history and medications prescribed, including the strength, amount, directions for use and refills
  - Therapies and other prescribed regimen
  - Follow-up plans, including consultation, referrals and directions, including time to return

A member's medical record shall include the following minimal detail for hospitals and mental hospitals:

- Identification of the beneficiary
- Physician name
- Date of admission and dates of application for and authorization of Medicaid benefits, if application is made after admission; and the plan of care, as required under 42 CFR 456.172 (mental hospitals) or 42 CFR 456.70 (hospitals)
- Initial and subsequent continued stay review dates, described under 42 CFR 456.233 and 42 CFR 465.234 (for mental hospitals) and 42 CFR 456.128 and 42 CFR 456.133 (for hospitals)
- Reasons and plan for continued stay, if applicable
- Other supporting material the committee believes appropriate to include
- For nonmental hospitals only:
  - Date of operating room reservation
  - Justification of emergency admission, if applicable

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; the Women, Infant and Children nutrition program (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.

Kentucky Health Information Exchange

Humana – CareSource encourages all providers in our network to establish connectivity with the Kentucky Health Information Exchange (KHIE) and recommends hospitals submit Admission, Discharge and Transfer messages (ADT) to KHIE. If providers do not have an electronic health record, Humana – CareSource encourages the providers to sign a participation agreement with KHIE and sign up for Direct Secure Messaging services so clinical information can be shared securely with other providers in their community of care. Please note that the Department for Medicaid Services may, at its discretion, mandate provider participation with at least 90 days written notice to Humana – CareSource.

The KHIE is an interoperable network in which participating providers with certified electronic health record technology (CEHRT) can access, locate and share needed patient health information with other providers, at the point of care.

The Health Information Exchange provides a common, secure electronic information infrastructure that meets national standards to ensure interoperability across various health systems, while affording providers the functionality to support preventive health and disease management.

KHIE serves as the intermediary for public health reporting in the state of Kentucky and works with providers and hospitals. Ultimately, KHIE strives to improve care coordination and overall health outcomes while facilitating the adoption, integration, and the meaningful use of CEHRT.

Visit the KHIE website and learn how to make the KHIE Connection at khie.ky.gov/Pages/index.aspx.

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 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 Medical Director, Kentucky Market. 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.

Program Scope

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

- 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 (QAC) is delegated by the board to monitor and evaluate the quality assessment and performance improvement (QAPI) program. This committee also is responsible for identifying, planning and implementing interventions to promote continuous quality improvement.

Access Standards

The quality improvement program includes evaluation of the availability, accessibility and acceptability of services rendered to members by participating 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.

Primary Care Providers

Patients with:	Should be seen:
Emergency needs	Immediately upon presentation; 24 hours a day, seven days a week
Urgent care	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

NonPCP Specialists

Patients with:	Should be seen:
Emergency needs	Immediately upon presentation
Urgent care	Not to exceed 48 hours
Routine care needs	Not to exceed 30 days from date of a member's request

Behavioral Health Providers

Patients with:	Should be seen:
Emergency care	Must be provided within six hours, crisis stabilization
Urgent care	Within 48 hours
Routine office visit	Shall not exceed 10 business days
Postdischarge from an acute psychiatric hospital	Within seven days, but may not exceed 14 days*

*Providers must contact members who have missed an appointment within 24 hours to reschedule.

Other referrals may not exceed 60 days.

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 30 days for regular appointments and 48 hours for urgent care.

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 healthcare outcomes, Humana – CareSource supports and encourages continuity of care and coordination of care between medical providers as well as between medical providers and behavioral health providers.

Preventive Guidelines and Clinical Practice Guidelines

These clinical treatment protocols are systematically developed statements that help providers and members make decisions regarding appropriate healthcare for specific clinical circumstances or for specific age ranges. We strongly encourage providers to use these guidelines and to consider these guidelines whenever they promote positive outcomes for clients.

The use of these guidelines allows Humana – CareSource to measure the impact of the guidelines on outcomes of care. Humana – CareSource monitors provider implementation of guidelines through the use of claim, pharmacy and utilization data. Treatment protocols, based on national standards, are developed with the input of local providers who are part of Humana – CareSource Quality Improvement committees.

Preventive health guidelines and clinical practice guidelines are distributed in writing by mail, fax or email to all new and existing providers through the following formats:

- Provider manual updates
- Provider newsletters
- Provider website

Providers also can receive preventive health and clinical practice guidelines through the care management department or their provider relations Representative. Preventive guidelines and clinical practice guidelines also are available on our "Health Care Links" webpage at **CareSource.com** > Providers > Education > Patient Care > Health Care Links, selecting Kentucky Medicaid from the menu.

Clinical Practice Registry

Accessible through our secure provider portal at **CareSource.com** > Login > Provider, selecting Kentucky from the menu, the clinical practice registry helps PCPs improve patient health outcomes. The primary use of the registry is to help PCPs manage member population. PCPs can quickly sort their Humana – CareSource membership into actionable groups to identify areas of focus. The clinical practice registry is a proactive approach to patient care and helps place emphasis on preventive care.

Key benefits of the registry include the following:

- After historical data is collected, the registry is color-coded and will provide easy identification of members in need of tests and/or screenings.
- The information can be downloaded as a PDF or to an Excel spreadsheet format (the Excel spreadsheet contains patient contact information).

Quality Performance Measures

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.

The National Committee for Quality Assurance (NCQA) accredits and certifies a wide range of healthcare 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 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 initiative. 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 and 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 www.ncqa.org.

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

HEDIS Measures

Adult Body Mass Index (BMI)
The percentage of members 18 to 74 who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year.

Controlling High Blood Pressure (CBP)
This intermediate-outcome measure assesses members 18 to 85 with a diagnosis of hypertension with blood pressure adequately controlled (less than 140/90 mm Hg).

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC)
This measure assesses the percentage of members 3 to 17 who had an outpatient visit with a primary care practitioner/OB-GYN and had evidence of the following during the measurement year:

- BMI percentile documentation
- Counseling for nutrition
- Counseling for physical activity

Annual Dental Visit (ADV)
This mesure looks at Medicaid members' use of the organization's dental servies. It measures the percentage of members 2 to 21 with dental coverage who had a dental check-up during the past year.

Lead Screening in Children (LSC)
This measure assesses the percentage of children two years of age who received one or more capillary or venous lead-blood test for lead poisoning on or before their second birthday.

Well-Child Visits in the First 15 Months of Life (W15)
This measure looks at the adequacy of well-child care for infants. It measures the percentage of children who had between on and six or more well-child visits by the time they turned 15 months.

Adolescent Well-Care Visits (AWC)
The percentage of enrolled members 12 to 21 who had at least one comprehensive well-care visit with a PCP or an obstetrics/gynecology (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 Adolescent Access to Primary Care Practitioners
The percentage of members 12 months to 19 years who had a visit with a PCP.

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

Seven-Day Follow-Up after Hospitalization for Mental Illness
Individuals six years and older who were hospitalized for treatment of selected mental health disorders must have a follow-up consultation with a mental health practitioner (e.g., psychiatrist, psychologist, psychiatric nurse practitioner or clinical nurse specialist, masters prepared social worker, certified marital and family therapist [MFT] or professional counselor [PCC, PCC-S]) within seven days of discharge.

Prenatal and Postpartum Care
The percentage of deliveries of live births between Nov. 6 of the year prior to the measurement year and Nov. 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
- **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
- CMS-416 EPSDT Services: Dental Services
- Adolescent preventive screening/counseling
- Individuals with special healthcare needs (ISHCN) access and preventive care
- Weight assessment, nutrition and physical activity counseling for children and adolescents
- Weight/BMI assessment, nutrition and physical activity counseling for adults

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 providers
- Assessment of quality and appropriateness of care furnished to children with special healthcare needs
- Continuity and coordination of care
- HEDIS measurement
- Consumer Assessment of Health Plan Survey (CAHPS)
- Annual measurement of effectiveness review of the QAPI

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.

Medical Record Review

You may periodically receive requests for medical record copies from an EQRO or from Humana – CareSource for a 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 healthcare possible for our members.

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 utilization 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 our providers 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.

FRAUD, WASTE & ABUSE

Healthcare 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.

Definitions & Examples

Fraud is defined as "… an intentional deception or misrepresentation made by a recipient or a 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 healthcare." 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 goods or services 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 (i.e., identity theft)
- Providing inaccurate symptoms and other information to providers in order to receive 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 IDs resulting in claims submitted for noncovered 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 branded 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 employees who are debarred
- Billing for services not rendered
- Billing for a more-expensive service, but providing a less-expensive service

Corrective Actions

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/providers/medicaid/.

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.

Federal & State Laws

False Claims Act

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:

- Knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval

- Knowingly make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim
- Conspire to commit a violation of other sections of the False Claims Act
- Have possession, custody or control of property or money used, or to be used, by the government and knowingly deliver, or cause to be delivered, less than all of that money or property
- Are 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, make or deliver the receipt without completely knowing that the information on the receipt is true
- Knowingly buy, or receive 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
- Knowingly make, use, or cause 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 conceal or knowingly and improperly avoid or decrease 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.

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 an 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 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 a false, fictitious or fraudulent statement, representation, or entry in an 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 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 false, fictitious or fraudulent statement or entry.

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

Protection for Whistleblowers

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 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.

Individuals bringing the suit may receive a percentage of the proceeds of the action or settlement. Additional information on the False Claims Act and our fraud, waste and abuse policies can be found on our Fraud, Waste & Abuse webpage at **CareSource.com** > Providers > Education > Fraud, Waste & Abuse, selecting Kentucky Medicaid from the menu.

Anti-Kickback Statute

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 items or services for which payment may be made in whole or in part under a federal healthcare program. (42 U.S.C. §1320a-7b)

Stark Law

Under the federal Stark Law and subject to certain exceptions, physicians are prohibited from referring federal healthcare 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 healthcare programs. (42 U.S.C. §1395[a] and §1903[s])

Health Insurance Portability and Accountability Act (HIPAA)

As part of 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 a federal healthcare program or obtain by means of false or fraudulent pretenses, representations or promises, money or property owned by or under the custody or control of a federal healthcare program. 18 U.S.C. §1347.

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 non-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 healthcare 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.

Reporting Fraud, Waste & Abuse

It is Humana – CareSource's policy to detect and prevent 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 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

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

Or you may choose to use the Fraud, Waste and Abuse Reporting Form located on our Forms webpage at **CareSource.com** > Providers > Tools & Resources > Forms, selecting Kentucky Medicaid from the menu.

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 contact you 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 to help providers understand 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 oig.hhs.gov/compliance/physician-education/index.asp.

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

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

CREDENTIALING

Humana – CareSource credentials and recredentials all licensed independent practitioners including physicians, facilities and nonphysicians 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 healthcare practitioners. Our senior clinical staff person is responsible for the credentialing and recredentialing program.

Provider Credentialing

Any provider who serves Kentucky Medicaid beneficiaries must be enrolled with the commonwealth of Kentucky Department for Medicaid Services (KDMS) as a Medicaid provider. Per 907KAR1:672(2)(c)(1), an individual or entity that wishes to participate in the Medicaid program shall be enrolled as a participating provider prior to being eligible to receive reimbursement in accordance with federal and state laws. Humana – CareSource cannot reimburse a provider for services rendered to our members unless the provider is enrolled with an effective date which covers the date of service on the claim.

For details on how to apply to be a Kentucky Medicaid enrolled provider please visit chfs.ky.gov/agencies/dms/dpi/pe/Pages/default.aspx or call 1-877-838-5085.

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.

CAQH Application

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

Humana – CareSource
Attention: Credentialing
101 E. Main St.
Louisville, KY 40202
Fax: 1-502-508-0521

Humana – CareSource is a participating organization with the Council for Affordable Healthcare (CAQH). Please make sure that we have access to your provider application by:

1. Logging onto the CAQH website at www.caqh.org/ utilizing your account information
2. Selecting the Authorization Tab
3. Making sure Humana – CareSource is listed as an authorized health plan; 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 Face 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 recredentialing activities utilizing the guidelines from the Kentucky Department of Medicaid Services (KDMS), the Centers for Medicare & Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA).

Provider Types

Contracted providers listed in the provider directory are credentialed along with the following practitioner types:

- 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.
- Nonphysician 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)

Selection Criteria

Humana – CareSource is committed to providing the highest level of quality care and service to our members. Our providers are critical business partners with us in that endeavor. As a result, we developed the following provider selection criteria to facilitate an optimal level of care and service, as well as promote 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 a high 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 recredentialing process, in addition to day-to-day monitoring via internal mechanisms and interactions with our members.

Selection criteria includes:

- Active and unrestricted license in the state issued by the appropriate licensing board
- Previous five-year work history
- Current Drug Enforcement Administration (DEA) certificate (if applicable)
- Successful completion of all required education
- Successful completion of all training programs pertinent to one's practice
- For M.D.s and D.O.s, successful completion of residency training pertinent to the requested practice type
- For dentists and other providers in which special training is required or expected for services being requested, successful completion of training
- Board certification, if applicable
- Education, training and experience are current and appropriate to the scope of practice requested
- Malpractice insurance at specified limits established for all practitioners by the credentialing policy
- Good standing with Medicaid and Medicare
- Medicaid number
- Quality of care and practice history as judged by:
  - Medical malpractice history
  - Hospital medical staff performance
  - Licensure or specialty board actions or other medical and/or civil disciplinary actions
  - 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
  - Other quality of care measurements/activities
  - Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing
  - Lack of issues on Health & Human Services – Office of Inspector General (HHS-OIG); General Services Administration (GSA, formerly EPLS)
- Signed, accurate credentialing application and contractual documents
- Compliance with standards of care and evidence of active initiatives to engage members in preventive care

- Agreement to comply with plan formulary requirements or acceptance of plan preferred drug list as administered through pharmacy benefit manager
- Agreement to access and availability standards established by the health plan
- Compliance with service requirements outlined in the provider agreement and provider manual

Organizational Credentialing

Organization Types

The following organizational providers are credentialed and recredentialed:

- 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
- Free standing birth centers

Selection Criteria

The following elements are assessed for organizational providers:

- Provider is in good standing with state and federal regulatory bodies
- Provider has been reviewed and approved by an accrediting body
- Every three years is still in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body
- Liability insurance coverage is maintained

- Copy of facility's state license (if applicable)
- Clinical Laboratory Improvement Amendments (CLIA) certificates are current
- Completion of a signed and dated application

Required Disclosures

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 healthcare 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.

Practitioner Rights

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

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 information obtained during the credentialing or recredentialing process varies substantially from the application, the practitioner is 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 recredentialing application upon written request to the credentialing department.

Ongoing Compliance

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 an event reportable to the National Practitioner Data Bank (NPDB).

Recredentialing

Providers are recredentialed a minimum of every three years. As part of the recredentialing 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 recredentialed unless otherwise notified.

Delegation of Credentialing

Humana – CareSource will only enter into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated is accredited by the National Committee for Quality Assurance (NCQA) for these functions, utilizes a NCQA-accredited credentials verification organization (CVO) and/or successfully passes a pre-delegation audit demonstrating compliance with NCQA federal and state requirements.

A predelegation audit must be completed prior to entering into a 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 recredentialing policies and procedures
- Credentialing and recredentialing committee meeting minutes from the previous year
- Credentialing and recredentialing 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.

Credentialing Appeals

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. Participating providers can appeal if they are affected by an adverse determination.

Submit appeal requests in writing to the senior medical director, along with other supporting documentation.

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.

Please send your appeal requests 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: Quality Improvement
500 W. Main St.
Louisville, KY 40202

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

Humana – CareSource
Attn: 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.

Kentucky Medicaid MCO
Provider Grievance Form

Check the box of the plan you are filing the grievance with	MCO	Phone	Fax
	☐ Anthem BCBS Medicaid	1-855-661-2028	502-212-7336
	☐ CoventryCares/Aetna Better Health	1-855-300-5528	1-855-454-5585
	☐ Humana – CareSource	1-855-852-7005	1-855-262-9794
	☐ Passport Health Plan	1-800-578-0775	502-585-8340
	☐ WellCare of Kentucky	1-877-389-9457	1-866-388-1769

Please complete all appropriate fields

If you need assistance with this form, call your MCO at the number listed above
All Grievances must be filed within 30 days from the date of MCO action

Date _____

Provider Name _____ **Address** _____

City _____ **State** _____ **County** _____

NPI# _____ **Email** _____ **Phone** _____

Name of person filing Grievance _____ _____

What is the Grievance/Complaint about?

I am having trouble with the following: (Check all that apply)

☐ Billing Policy	☐ Credentialing	☐ Provider Representative
☐ Claims Dispute	☐ Denial of Service	☐ Service
☐ Communications	☐ Eligibility	☐ Slow Payment
☐ Coordination of Benefits	☐ Excessive Wait Times	☐ Other

Please give as much detail as possible about this complaint/grievance:

Signature of person filing grievance _____ _____ Date _____

This form complies with the Grievance process as outlined in KAR 17:010

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Kentucky Medicaid MCO
Provider Appeal Request

Check the box of the plan in which the provider is enrolled	MCO	Phone	Fax
	☐ Anthem BCBS Medicaid	1-855-661-2028	502-212-7336
	☐ CoventryCares/Aetna Better Health	1-855-300-5528	1-855-454-5585
	☐ Humana – CareSource	1-855-852-7005	1-855-262-9793
	☐ Passport Health Plan	1-800-578-0636	502-585-8461
	☐ WellCare of Kentucky	1-877-389-9457	1-866-201-0657

Please complete all appropriate fields

If you need assistance with this form, call your MCO at the number listed above

All Appeals must be filed within 30 days from the date of MCO action

Date _____

Person filing request _____ **Email** _____ **Phone** _____

If filing on behalf of provider, state relationship to provider _____

Who is the Appeal for?

Provider's name _____ Provider's NPI _____

Providers address _____ _____ County _____

City _____ State _____ Zip _____

Why are you requesting an appeal?

Is this an expedited request? ☐ Yes Reason _____

This request for an appeal is a ☐ Payment issue - Claim number _____ DOS _____

☐ Authorization issue ☐ Post-service

☐ Contract issue ☐ Other _____

Please give as much detail as possible about this issue:

Attach a copy of the denial letter along with any other correspondence concerning this request.

Signature of person filing request _____ _____ Date _____

This form complies with the Appeals process as outlined in KAR 17:010

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