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INTRODUCTION

Welcome
Welcome to Kentucky Spirit Health Plan. We thank you for being part of Kentucky Spirit Health Plan network of participating physicians, hospitals, and other healthcare professionals. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. Kentucky Spirit Health Plan works to accomplish this goal by partnering with the providers who oversee the healthcare of Kentucky Spirit Health Plan’s members.

About US
Kentucky Spirit Health Plan is a Managed Care Organization (MCO) contracted with the Kentucky Cabinet for Health and Family Services to serve Kentucky members through the Medicaid program. Kentucky Spirit Health Plan has the expertise to work with Kentucky members to improve their health status and quality of life. Kentucky Spirit Health Plan’s parent company, Centene Corporation (“Centene”), has been providing comprehensive managed care services to individuals receiving benefits under Medicaid and other government-sponsored healthcare programs for more than twenty-five years. Centene operates local health plans and offers a wide range of health insurance solutions to individuals and to the rising number of uninsured Americans. Centene also contracts with other healthcare and commercial organizations to provide specialty services.

Kentucky Spirit Health Plan is a physician-driven organization that is committed to building collaborative partnerships with providers. Kentucky Spirit Health Plan will serve our Kentucky members consistent with our core philosophy that quality healthcare is best delivered locally.

Mission
Kentucky Spirit Health Plan strives to provide improved health status, successful outcomes, and member and provider satisfaction in a managed care environment. Kentucky Spirit Health Plan has been designed to achieve the following goals:

- Ensure access to primary and preventive care services
- Ensure care is delivered in the best setting to achieve an optimal outcome
- Improve access to all necessary healthcare services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

All of our programs, policies and procedures are designed with these goals in mind. We hope that you will assist Kentucky Spirit Health Plan in reaching these goals and look forward to your active participation.

How to Use This Manual
Kentucky Spirit Health Plan is committed to working with our provider community and members to provide a high level of satisfaction in delivering quality healthcare benefits. We are committed to provide comprehensive information through this Provider Manual as it relates to Kentucky Spirit Health Plan operations, benefits, and policies and procedures to providers. Please contact the Provider Services department (“Provider Services”) at 1-866-643-3153 if you need further explanation on any topics discussed in the manual.
KEY CONTACTS

The following chart includes several important telephone and fax numbers available to your office. When calling Kentucky Spirit Health Plan, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number (“TIN”) number
- Member’s ID number or Medicaid ID number

### Health Plan Information

<table>
<thead>
<tr>
<th>Department</th>
<th>Telephone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services</td>
<td>1-866-643-3153</td>
<td>1-866-662-2032</td>
</tr>
<tr>
<td>Member Services</td>
<td>1-866-643-3153</td>
<td>1-855-252-0565</td>
</tr>
<tr>
<td></td>
<td>1-855-790-5051</td>
<td></td>
</tr>
<tr>
<td>Authorization Request</td>
<td>1-866-643-3153</td>
<td>1-855-252-0567</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>1-855-252-0568</td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td>1-855-252-0561</td>
<td></td>
</tr>
<tr>
<td>Cenpatico</td>
<td>1-855-790-5056</td>
<td>1-855-254-1798</td>
</tr>
<tr>
<td>NurseWise</td>
<td>1-866-643-3153</td>
<td>1-866-645-3153</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
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</tr>
<tr>
<td>Medical Claims</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reimbursement Rate Dispute</td>
<td>Kentucky Spirit Health Plan</td>
<td></td>
</tr>
<tr>
<td>Medical Necessity Appeal</td>
<td>Kentucky Spirit Health Plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attn: Claims</td>
<td>Attn: Claim Disputes</td>
</tr>
<tr>
<td></td>
<td>PO Box 4001</td>
<td>PO Box 3000</td>
</tr>
<tr>
<td></td>
<td>Farmington, MO 63640-4401</td>
<td>Farmington, MO 63640-3800</td>
</tr>
<tr>
<td>Electronic Claims Submission</td>
<td>Kentucky Spirit Health Plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attn: Medical Necessity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>201 East Main Street</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lexington, Kentucky 40507</td>
<td></td>
</tr>
</tbody>
</table>

### PRODUCT SUMMARY

The Kentucky Cabinet for Health and Family Services, Department for Medicaid Services (Department) is the state agency responsible for the implementation and administration of the Kentucky Medicaid Program, including the Medicaid Managed Care Program under which Kentucky Spirit Health Plan provides services.

The population of Kentucky Spirit Health Plan Managed Care Network is comprised of beneficiaries whom are in a category of eligibility listed below.
Mandatory Populations

- Temporary Assistance to Needy Families (TANF)
- Aged, blind, and disabled Medicaid only and receiving Supplemental Security Income (SSI)
- Pregnant women
- Dual Eligibles
- Children in Foster Care
- Disabled Children

Excluded Populations

- Individuals who shall spend down to meet eligibility income criteria
- Individuals currently Medicaid eligible and have been in a nursing facility for more than thirty days
- Individuals determined eligible for Medicaid due to a nursing facility admission including those individuals eligible for institutionalized hospice
- Individuals served under the Supports for Community Living, Michele P, home and community-based, or other 1915© Medicaid waivers
- Qualified Medicare Beneficiaries (QMBs), specified low income Medicare beneficiaries (SLMBs) or qualified Disabled Working individuals (QDWIs)
- Timed limited coverage for illegal aliens for emergency medical conditions
- Working Disabled Program
- Individuals in an intermediate care facility for mentally retarded (ICF-MR)
- Individuals who are eligible for the Breast or Cervical Cancer Treatment Program

VERIFYING ELIGIBILITY

Member Eligibility Verification

To verify member eligibility, please use one of the following methods:

1. **Log on to the secure provider portal at [www.KentuckySpiritHealth.com](http://www.KentuckySpiritHealth.com).** Using our secure provider portal, you can check member eligibility. You can search by date of service and either of the following: member name and date of birth, or member Medicaid ID and date of birth.

2. **Call our automated member eligibility IVR system.** Call 1-866-643-3153 from any touch tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24 hours a day. The automated system will prompt you to enter the Medicaid ID number and the month of service to check eligibility.

3. **Call Kentucky Spirit Health Plan Provider Services.** If you cannot confirm a member’s eligibility using the methods above, call our toll-free number at 1-866-643-3153. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will need the member name, Medicaid ID number or verify eligibility.

Through Kentucky Spirit Health Plans’ secure provider web portal, Primary Care Providers (PCPs) are able to access a list of eligible members who have selected their services or were
assigned to them. The Patient list is reflective of all changes made within the last 24 hours. The list also provides other important information including date of birth and indicators for members who are patients who based on claims data may have a gap in care, such as missed an Early Periodic Screening, Diagnosis and Treatment (EPSDT) exam. In order to view this list, log on to www.KentuckySpiritHealth.com to access the secure provider web portal. **Since eligibility changes can occur throughout the month and the member list does not prove eligibility for benefits or guarantee coverage, please use one of the above methods to verify member eligibility on date of service.**

Once eligibility is confirmed, all new Kentucky Spirit Health Plan members receive a Kentucky Spirit Health Plan member ID card. Members will keep their state issued ID card to receive services not covered by the plan. 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. **Since member ID cards are not a guarantee of eligibility, providers must verify members’ eligibility on each date of service.**

### Member Identification Card

Members must present a member ID card each time services are rendered by a provider. If you are not familiar with the person seeking care as a member of our health plan, please ask to see photo identification. If you suspect fraud, please contact Provider Services at 1-866-643-3153 immediately.
Kentucky Spirit Health Plan’s Website

The Kentucky Spirit Health Plans’ website can significantly reduce the number of telephone calls providers need to make to the health plan. Utilizing the website allows immediate access to current provider and member information 24 hours, seven days a week. Please contact your Provider Relations Representative or our Provider Services department at 1-866-643-3153 with any questions or concerns regarding the website.

Kentucky Spirit Health Plans’ website is located at www.KentuckySpiritHealth.com. Physicians and office staff can query information including:

- Provider Manual
- Provider Billing Manual
- Prior Authorization List
- Forms
- Kentucky Spirit Health Plan news
- Clinical guidelines
- Provider newsletters
- Preferred Drug List (PDL)

Secure Website

Kentucky Spirit Health Plans’ web portal services allows providers to check member eligibility and benefits, submit and check status of claims, request authorizations and send messages to communicate with Kentucky Spirit Health Plan staff. Kentucky Spirit Health
Plans’ contracted providers and their office staff have the opportunity to register for our secure provider website in just 4-easy steps. Here, we offer tools which make obtaining and sharing information easy! It’s simple and secure! Go to www.KentuckySpiritHealth.com and register. On the home page, select the Login link on the top right to start the registration process.

Through the secure site you can:
- Check member eligibility
- View the PCP panel (patient list)
- View and submit claims and adjustments
- View payment history
- View and submit authorizations
- View payment history
- View member gaps in care
- View quality scorecard
- Contact us securely and confidentially

We are continually updating our website with the latest news and information, so save the website address to your Internet “Favorites” list. Please contact your Provider Relations Representative for a tutorial of the secure site.

**PROVIDER RESPONSIBILITIES**

**Primary Care Provider (PCP) Responsibilities**

The PCP is the cornerstone of Kentucky Spirit Health Plans’ service delivery model. The PCP serves as the “medical home” for the Kentucky Spirit Health Plan member by establishing a member-provider relationship, supporting the continuity of care, ensuring patient safety, eliminating redundant services and ultimately providing more cost effective care and better health outcomes.

The PCP must:

- Establish and maintain hospital admitting privileges sufficient to meet the needs of assigned members, or entering into formal arrangements for management of inpatient hospital admissions of members
- Agree to provide or arrange to primary services 24 hours a day, seven days week
- Manage the medical and healthcare needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety at all times
- Educate members on how to maintain healthy lifestyles and prevent serious illness
- Provide screenings, well-care and referrals to community health departments and other agencies in accordance with the States provider requirements and public health initiatives
- Offer hours of operation that are no less than the operating hours offered to commercial members or comparable to commercial health plans if the PCP does not provide health services to commercial members
• Provide referrals for specialty care and other medically necessary services both in and out of network, which the PCP does not provide, including referrals to behavioral health providers
• Ensure follow-up and documentation of all referrals
• Maintain a current and complete medical record for the member in a confidential manner, including documentation of all services and referrals provided to the member, including but not limited to - services provided by the PCP, specialists, and providers of ancillary services.
• Adhere to the EPSDT periodicity schedule
• Follow established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for selected inpatient and selected outpatient services as listed on the prior authorization list, except for emergency services up to the point of stabilization
• Actively participate in and cooperate with all Kentucky Spirit Health Plan quality initiatives and programs.
• Discuss Advance Medical Directives with members
• Provide referrals for members who are in the Lock-In Program (Please see information on the Lock-In Program under the Fraud and Abuse Section of this manual)
• Ensure the member’s privacy, medical records are kept in a secure location

Referrals

It is Kentucky Spirit Health Plans’ preference that the PCP coordinates healthcare services. PCPs are encouraged to refer a member when medically necessary care is needed that is beyond the scope of what the PCP can provide. Paper referrals are not required. The PCP must obtain prior authorization from Kentucky Spirit Health Plan for referrals to certain specialty providers as noted on the prior authorization list. All out-of-network services require prior authorization as further described herein except for family planning services. A provider is also required to promptly notify Kentucky Spirit Health Plan when prenatal care is rendered.

Providers are prohibited from making referrals for designated health services to healthcare entities with which the provider or a member of the providers’ family has a financial relationship.

Provider Types That May Serve As A PCP

Physicians who may serve as a PCP include a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), primary care physician residents, physician assistant, or clinic (including FQHC, primary care center and rural health clinic), that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges and agrees to provide 24 hour per day, seven day a week primary healthcare services to individuals. Specialty providers may serve as PCPs under certain circumstance, depending on the member’s need.

Member Panel Capacity

The PCP panel size for Kentucky Spirit Health Plan members may not exceed 1,500. All PCPs reserve the right to state the number of members they are willing to accept into their
panel. Kentucky Spirit Health Plan **DOES NOT** guarantee that any provider will receive a certain number of members.

If a PCP declares a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact Kentucky Spirit Health Plans’ Provider Services at 1-866-643-3153. A PCP shall not refuse to treat members as long as the physician has not reached their requested panel size.

Providers shall notify Kentucky Spirit Health Plan in writing at least 45 days in advance of his or her inability to accept additional Medicaid covered persons under Kentucky Spirit Health Plan agreements. In no event shall any established patient who becomes a Covered Person be considered a new patient. Kentucky Spirit Health Plan prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.

**Assignment of Medical Home**

Kentucky Spirit Health Plan offers a robust network of primary care providers to ensure every member has access to a “medical home” within the required travel distance standards (30 miles or 30 minutes in the urban areas and 45 miles or 45 minutes in the rural areas).

For SSI non-dual members who have not selected a PCP within 90 days of their enrollment and 30 days for all other members not under the oversight of DCBS, Kentucky Spirit Health Plan will use an auto-assignment algorithm to assign an initial PCP. The algorithm assigns members to a PCP according to the following criteria, and in the sequence presented below:

1. **Member history with a PCP based on state data.** The algorithm will first look for previous relationship with a network PCP.

2. If no match is found and the member is a returning member, the algorithm will attempt to match them to previous PCP.

3. **Family history with a PCP.** If the member has no previous relationship with a PCP, the algorithm will look for a PCP that someone in the member’s family, such as a sibling, is or has been assigned to.

4. **Geographic proximity of PCP to member residence.** The auto-assignment logic will ensure members travel no more than 30 miles in the urban areas and 45 miles in rural areas.

5. **Appropriate PCP type.** The algorithm will use age, gender, and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant moms assigned to OB/GYNs.

**Specialist Responsibilities**

In alignment with the Medical Home concept, Kentucky Spirit encourages specialists to communicate with the members’ PCP regarding all assessment, diagnostic testing, and treatment including referral to another specialists or admission to a hospital. This allows the PCP to better coordinate the members’ care and makes the PCP aware of the additional services requested.
Emergency admissions will require notification within 2 business days of admission. All non-emergency inpatient admissions require prior authorization from Kentucky Spirit.

The specialist provider must:

- Obtain a Prior Authorization from Kentucky Spirit’s Medical Management department (“Medical Management”) as needed, before providing services that require prior authorization
- Coordinate the member's care with the PCP
- Provide the PCP with consult reports and other appropriate records within ten (10) business days
- Be available for or provide on-call coverage through another source twenty-four (24) hours a day for management of member care
- Maintain the confidentiality of medical information
- Actively participate in and cooperate with all Kentucky Spirit quality initiatives and programs
- Ensure the member's privacy, medical records are kept in a secure location

Kentucky Spirit Health Plan providers should refer to their contract for complete information regarding providers’ obligations or contact their Provider Relations Representative.

Appointment Accessibility Standards
Kentucky Spirit Health Plan follows the accessibility requirements set forth by applicable regulatory and accrediting agencies and Kentucky Spirit Health Plan monitors compliance with these standards on an annual basis.

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Scheduling Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Providers</strong></td>
<td></td>
</tr>
<tr>
<td>Routine, non-urgent, or preventative care visits</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Emergent or emergency visits</td>
<td>Immediately upon presentation</td>
</tr>
<tr>
<td><strong>Specialty Care</strong></td>
<td></td>
</tr>
<tr>
<td>Routine, non-urgent, or preventative care visits</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td><strong>Behavioral Health Services</strong>*</td>
<td></td>
</tr>
<tr>
<td>Emergency care with crisis stabilization</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>*Services may not exceed fourteen (14) days post discharge from an acute Psychiatric Hospital and sixty (60) days for other referrals</td>
<td></td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td></td>
</tr>
<tr>
<td>Routine appointment</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Vision</td>
<td></td>
</tr>
<tr>
<td>Routine appointment</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 48 hours</td>
</tr>
</tbody>
</table>

**Covering Providers**

PCPs and specialty physicians must arrange for coverage with another Kentucky Spirit Health Plan participating provider during scheduled or unscheduled time off. The covering provider will be reimbursed accordance with the terms of his/her contractual agreement. In the event of scheduled or unscheduled time off, please notify Provider Services of coverage arrangements.

**Telephone Arrangements/24-Hour access**

Kentucky Spirit Health Plans’ PCPs and specialty physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services and shall ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider’s office phone must be answered during normal business hours
- Answer the member’s telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a member
- Identify and reschedule broken and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
  - After hours telephone care for non-emergent, symptomatic issues within 30 minutes
  - Same day for non-symptomatic concerns
  - Crisis situations within 15 minutes
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider’s absence
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member’s medical record
- During after-hours, a provider must have arrangements for:
  1. Office phone is answered after hours by an answering machine 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
  2. 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; and
3. 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

**Note:** If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility that the member is being referred there. Notification is not required prior to member receiving urgent or emergent care.

Kentucky Spirit Health Plan will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement program (“QIP”).

**Consent Forms**

Certain covered services require the member to provide written consent prior to the delivery of the benefit. In these situations, the provider who will deliver the care must ensure that the member has written consent before Kentucky Health Spirit may reimburse the provider for that service. The following are services for which consent must be obtained and the link from where the necessary Consent Forms may be downloaded. These links may also be found in our website at www.KentuckySpiritHealth.com.

<table>
<thead>
<tr>
<th>Service</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other: (Induced Premature Birth)</td>
<td><a href="http://www.kymmis.com/kymmis/pdf/map236.pdf">http://www.kymmis.com/kymmis/pdf/map236.pdf</a></td>
</tr>
</tbody>
</table>

* Hysterectomy Consent Form is required at the time the service is prior authorized and does not need to be submitted with the claim.

**Hospital Responsibilities**

Kentucky Spirit Health Plan utilizes a network of hospitals to provide services to Kentucky Spirit Health Plan members.

Hospitals must:

- Obtain authorizations for selected inpatient and outpatient services as listed on the prior authorization list - *Emergency Room care does not require prior authorization*
- Notify Kentucky Spirit Health Plans’ Medical Management department of emergency hospital admissions, elective hospital admissions and new born deliveries within 24-48 hours of the admission
- Notify the PCP within 24-48 hours after the member’s visit to the emergency department
- Notify Kentucky Spirit Health Plans’ Medical Management department of members who may benefit from case management services – such as members who may have frequent visit to the emergency room
- Notify Kentucky Spirit Health Plans’ Medical Management department of Kentucky Spirit Health Plan member emergency room visits for the previous business day. This can be done via Fax or electronic file. The notification should include member’s
name, Medicaid ID, presenting symptoms, diagnosis, date of service, and member phone number, if available

Kentucky Spirit Health Plan hospitals should refer to their contract for complete information regarding the hospitals’ obligations and reimbursement.

**Advanced Directives**

Kentucky Spirit Health Plan is committed to ensuring its members are aware of and are able to avail themselves of their rights to execute advance directives. Kentucky Spirit Health Plan is equally committed to ensuring that its providers and staff are aware of their responsibilities to comply with state and federal laws regarding advance directive

PCPs and providers delivering care to Kentucky Spirit Health Plan members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

Kentucky Spirit Health Plan recommends to its participating providers that they inquire about advance directives and document the member's response in the medical record, and, for members who have executed advance directives, that a copy of the advance directive be included in the member’s medical record inclusive of mental health directives.

If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.

**Voluntarily Leaving the Network**

Providers must give Kentucky Spirit Health Plan notice of voluntary termination following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the member's new provider upon request and facilitate the member's transfer of care at no charge to Kentucky Spirit Health Plan or the member.

Kentucky Spirit Health Plan will notify affected members in writing of a provider’s termination, within 30 calendar days of the receipt of the termination notice from the provider, provided that such notice from the provider was timely. If the terminating provider is a PCP, Kentucky Spirit Health Plan will request that the member elect a new PCP within 10 business days of the postmark date of the termination of the PCP notice to members and provide information on options for selecting a new PCP. If a member does not elect a PCP prior to the provider's termination date, **Kentucky Spirit Health Plan** will automatically assign one to the member.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 days, the anniversary date of the member’s coverage, or until Kentucky Spirit Health Plan can arrange for appropriate healthcare for the member with a participating provider.
Upon request from a member undergoing active treatment related to a chronic or acute medical condition, Kentucky Spirit Health Plan will reimburse the provider for the provision of covered services for up to 90 days from the termination date. In addition, Kentucky Spirit Health Plan will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

Exceptions may include:

- Members requiring only routine monitoring
- Providers unwilling to continue to treat the member or accept payment from Kentucky Spirit Health Plan

Kentucky Spirit Health Plan will also provide written notice to a member within 30 days, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable.

**CULTURAL COMPETENCY**

Cultural competency within Kentucky Spirit Health Plan is defined as “the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural Competency is developmental, community focused and family oriented. In particular, it is the promotion of quality services to understand, racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.”

Kentucky Spirit Health Plan is committed to the development, strengthening and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

Kentucky Spirit Health Plan as part of its credentialing will evaluate the cultural competency level of its network providers and provide access to training and toolkits to assist provider’s in developing culturally competent and culturally proficient practices.

Network providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them
- Medical care is provided with consideration of the members’ race/ethnicity and language and its impact/influence of the members’ health or illness
- Office staff that routinely interact with members have access to and participate in cultural competency training and development
Office staff that is responsible for data collection makes reasonable attempts to collect race and language specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and their children.

Treatment plans are developed and clinical guidelines are followed with consideration of the members race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process.

Office sites have posted and printed materials in English and Spanish, and if required by the state, any other required non-English language.

Kentucky Spirit Health Plan encourages its participating providers to complete the U.S. Department of Health & Human Services Physician Practical Guide to Culturally Competent Care, which is a free on-line accredited educational program.

**BENEFIT EXPLANATION AND LIMITATIONS**

Kentucky Spirit Health Plan network providers supply a variety of medical benefits and services and described in Table 1. For questions regarding benefits and limitations, please contact Provider Services at 1-866-643-3153 from 8:00 a.m. to 6:00 p.m. Monday through Friday EST (excluding holidays). A Provider Services Representative will assist you in understanding the benefits.

Kentucky Spirit Health Plan covers, at a minimum, those core benefits and services specified in our Agreement with the State of Kentucky as follows:

**KENTUCKY SPIRIT HEALTH PLAN BENEFITS**

Kentucky Spirit Health Plan network providers supply a variety of medical benefits and services as specified in our Agreement with the State of Kentucky. For questions regarding benefits and limitations, please contact Provider Services at 1-866-643-3153 from 8:00 a.m. to 6:00 p.m. Monday through Friday EST (excluding holidays). A Provider Services Representative will assist you in understanding the benefits.

**GLOBAL CHOICES COPAYMENTS AND COINSURANCE**

This is the benefit plan for most Kentucky Medicaid members. This plan covers basic medical services. The maximum out-of-pocket amount is $225.00 per calendar year for Medical services and $225.00 per calendar year for pharmacy services. Some benefit limits can be increased if the service is medically necessary, but it requires prior approval. Co-pays do not apply to the following eligibility categories:

- Non-KCHIP Children
- Children under 19 years old who are in foster care
- Pregnant women
- Hospice care patients
- Personal Care or Family Care Home

Co-pays cannot be more than 5% of a family’s income per quarter.
Note: This is not a complete list of services. See Table 1 below for a more comprehensive list of benefits. If a service is not listed, there is no co-pay.

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit Limitation</th>
<th>Co-pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Inpatient Hospital Services</td>
<td></td>
<td>$50 co-pay per admission</td>
</tr>
<tr>
<td>Allergy Services</td>
<td>Shots and allergy treatments limited to children under 21</td>
<td>$0</td>
</tr>
<tr>
<td>Audiometric Services</td>
<td>Limited to children under 21 one audiologist visit per calendar year</td>
<td>$0</td>
</tr>
<tr>
<td>Behavioral Health Services**</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Limited to 26 visits per 12-month period for children and adults</td>
<td>$2 co-pay</td>
</tr>
<tr>
<td>Dental Services</td>
<td>Children under 21: - 2 cleanings per 12-month period - Extractions and fillings - 1 set of x-rays per 12-month period - Other dental services are available Adults 21 and over: - 1 cleaning per 12-month period - Limited to one dental visit per month/per provider - Extractions and fillings - 1 set of x-rays per 12-month</td>
<td>$2 co-pay</td>
</tr>
<tr>
<td>Dural Medical Equipment (DME)</td>
<td></td>
<td>3% co-insurance up to a maximum of $15 per month</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)</td>
<td>Limited to children under 21</td>
<td>$0</td>
</tr>
<tr>
<td>Emergency Ambulance</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>See Emergency Room section of this handbook</td>
<td>5% co-insurance for non-emergency visits not to exceed $6 per visit</td>
</tr>
<tr>
<td>End Stage Renal Disease and Transplants</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Family Planning</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Limited to children under 21 Not to exceed $800 per ear every 36 months</td>
<td>$0</td>
</tr>
<tr>
<td>Home Health Services</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Hospice (non-institutional)</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Service Type</td>
<td>Description</td>
<td>Co-pay</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Laboratory, Diagnostic and Radiology Services</td>
<td></td>
<td>$3</td>
</tr>
<tr>
<td>Maternity Services Nurse mid-wife services</td>
<td>Pregnancy-related services, Services for other conditions that might complicate pregnancy, 60 days postpartum pregnancy-related services</td>
<td>$0</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>At an approved setting: No limit for children under 21 Adults 21 and over are limited to 15 visits per calendar year</td>
<td>$0</td>
</tr>
<tr>
<td>Out-patient Hospital / Ambulatory Surgical Centers</td>
<td></td>
<td>$3</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>At an approved setting: No limit for children under 21 Adults 21 and over are limited to 15 visits per calendar year</td>
<td>$2</td>
</tr>
<tr>
<td>Physician Office Services</td>
<td></td>
<td>$2</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td></td>
<td>$2</td>
</tr>
<tr>
<td>Preventive Services</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>At an approved setting: No limit for children under 21 Adults 21 and over are limited to 10 visits per calendar year</td>
<td>$1</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>EPSDT and pregnant women only</td>
<td>$0</td>
</tr>
</tbody>
</table>
Tobacco Cessation Assessment

- No co-pay for the actual assessment;
- $2 co-pay for the office visit;
- No co-pay for the smoking cessation drugs;
- All drugs, if prescribed are covered and DO NOT require a prior authorization for the initial fill;
- Refills of the prescribed smoking cessation drugs require approval from the Division of Medical Management.

Vision Services

- Eyewear limited to children under 21
  Adults and children limited to 1 eye exam per calendar year
  $200 limit per calendar year.
  Maximum paid for one pair of glasses is $150.

$2 co-pay for ophthalmologic or optometric office visit

Global Choices Pharmacy Copayments

The table below lists the copayment for prescription medications if the member is part of the Global Choices plan. The copayment maximum for prescription medications is $225.00 for each year (January through December). If the member is pregnant or in long term care facility they are exempt from all copayments. There is no copayment for oral contraceptives or preferred smoking cessation products; however, these products are still counted in the monthly prescription limit.

<table>
<thead>
<tr>
<th>Drug Status</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic prescription drug or an atypical anti-psychotic drug if no generic equivalent for the atypical anti-psychotic drug exists for a recipient who does not have Medicare Part D drug coverage</td>
<td>$1.00</td>
</tr>
<tr>
<td>Preferred brand name drug for a recipient who does not have Medicare Part D drug coverage</td>
<td>$2.00</td>
</tr>
<tr>
<td>Non-preferred brand name drug* for a recipient who does not have Medicare Part D drug coverage</td>
<td>5% coinsurance, not to exceed $20.00 per non-preferred brand name drug prescription</td>
</tr>
</tbody>
</table>
*A non-preferred brand name drug is a medication that is not listed on the PDL. These drugs are approved using the PA process. A non-preferred drug may also be filled through the Continuity of Care (COC) benefit.

**FAMILY CHOICES COPYAMENTS AND COINSURANCE**

Family Choices is the Kentucky Medicaid benefit plan that covers most eligible children. This plan covers basic medical services. Kentucky Children’s Health Insurance Program (KCHIP) is part of the Family Choices Plan. The maximum out-of-pocket amount is $225.00 per calendar year for Medical services and $225.00 per calendar year for pharmacy services. Some benefit limits can be increased if the service is medically necessary, but it requires prior approval. Co-pays do not apply to the following eligibility categories:

- Non-KCHIP Children
- Children under 19 years old who are in foster care
- Pregnant women
- Hospice care patients
- Personal Care or Family Care Home

Co-pays cannot be more than 5% of a family’s income per quarter.

**Note:** *This is not a complete list of services. See Table 1 below for a more comprehensive list of benefits. If a service is not listed, there is no co-pay.*

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit Limitation</th>
<th>Co-pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Inpatient Hospital Services</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Allergy Services</td>
<td>Shots and allergy treatments limited to children under 21</td>
<td>$2 co-pay for office visit and testing</td>
</tr>
<tr>
<td>Audiometric Services</td>
<td>Limited to children under 21 one audiologist visit per calendar year</td>
<td>$0</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Limited to 26 visits per 12-month period for children and adults</td>
<td>$0</td>
</tr>
<tr>
<td>Dental Services</td>
<td>Children under 21, to include: 2 cleanings per 12-month period Extractions and fillings; 1 set of x-rays per 12-month period. Other dental services are available</td>
<td>$0</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Copayment</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)</td>
<td>Limited to children under 21. KCHIP III children are not eligible for EPSDT Special Services and non-emergency transportation.</td>
<td>$0</td>
</tr>
<tr>
<td>Emergency Ambulance</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>See Emergency Room section of this handbook</td>
<td>5% co-insurance for non-emergency visits not to exceed</td>
</tr>
<tr>
<td>End Stage Renal Disease and Transplants</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Family Planning</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Limited to children under 21. Not to exceed $800 per ear every 36 months</td>
<td>$0</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Limited to 25 visits per calendar year</td>
<td>$0</td>
</tr>
<tr>
<td>Hospice (non-institutional)</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Laboratory, Diagnostic and Radiology Services</td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

**Family Choices Pharmacy Copayments**

The table below lists the copayment for prescription medications if the member is part of the Family Choices plan. The copayment maximum for prescription medications is $225.00 for each year (January through December). If the member is pregnant or in long term care facility they are exempt from all copayments. There is no copayment for oral contraceptives or preferred smoking cessation products; however, these products are still counted in the monthly prescription limit.

<table>
<thead>
<tr>
<th>Drug Status</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic prescription drug or atypical anti-psychotic drug if no generic equivalent exists</td>
<td>$1.00</td>
</tr>
<tr>
<td>Preferred brand name drug</td>
<td>$2.00</td>
</tr>
<tr>
<td>Non-preferred brand name drug*</td>
<td>$3.00</td>
</tr>
</tbody>
</table>
A non-preferred brand name drug is a medication that is not listed on the PDL. These drugs are approved using the PA process. A non-preferred drug may also be filled through the Continuity of Care (COC) benefit.

**COVERED SERVICES’ LIMITATIONS AND PRIOR AUTHORIZATIONS**

Kentucky Spirit Health Plan provides covered services following the limitations prescribed by the State of Kentucky. In addition, Kentucky Spirit Health Plan requires prior authorization for some of the benefits covered under its program as indicated in the table below.

**Table 1: Benefits and Services Requiring Plan Authorization**

This list is not intended to be an all-inclusive list of covered services but it substantially provides current PA instructions. All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. Prior Authorization is required for any service beyond standard benefit limits. Member co-pays may apply to some services.

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit Limitation</th>
<th>Prior Authorization</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>Elective abortions are not covered.</td>
<td>No</td>
<td><em>Must submit form MAP 235: Certification for Induced Abortion or Induced Miscarriage with Claim.</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><em>Must submit form MAP 236: Certification for Induced Premature Birth with Claim.</em></td>
</tr>
<tr>
<td>Abortion</td>
<td>Must submit form MAP 235: Certification for Induced Abortion or Induced Miscarriage with Claim.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premature Induction of Labor</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance – Airplane</td>
<td>Yes</td>
<td></td>
<td>Prior authorization required for Fixed Wing (airplane) Ambulance Services</td>
</tr>
<tr>
<td>Ambulance – Emergent</td>
<td>No</td>
<td></td>
<td>Includes emergency ground and emergency helicopter ambulance</td>
</tr>
<tr>
<td>Ambulatory Surgery Center</td>
<td>No</td>
<td></td>
<td>Except as otherwise noted on this list</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>Includes Community Based, Inpatient and Outpatient Services.</td>
<td>See Comments</td>
<td>Prior authorization required for some services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Services administered by Cenpatico Behavioral Health.</td>
</tr>
<tr>
<td>Cardiac Rehab Services</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Limited to 26 visits/ 12 months</td>
<td>Yes</td>
<td>Prior authorization required</td>
</tr>
<tr>
<td>Dental - General Anesthesia</td>
<td>Yes</td>
<td></td>
<td>Prior authorization required</td>
</tr>
<tr>
<td>Dental Services</td>
<td>Includes semi-annual cleaning for member &lt;20 years old. Sealants for members age 5-20. Annual cleaning for members &gt;20 years old. One set of x-rays per/12 month period.</td>
<td>See Comments</td>
<td>Other services as per State Medicaid benefits including extractions and fillings. Services administered by MCNA. Some services require PA per MCNA policy.</td>
</tr>
<tr>
<td>Dialysis</td>
<td>No</td>
<td></td>
<td>Includes free standing and outpatient hospital setting</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>See Comments</td>
<td></td>
<td>Prior authorization required for the following items:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>* Apnea Monitor</td>
</tr>
</tbody>
</table>

Provider Services Department 1-866-643-3153 TDD/TTY 1-855-790-3153

23
<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit Limitation</th>
<th>Prior Authorization</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Periodic Screening Diagnosis and Treatment</td>
<td>For members less than 21 years old</td>
<td>No</td>
<td>EPSDT/ well child services</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Enteral &amp; Parenteral Nutrition for Home Use</td>
<td></td>
<td>Yes</td>
<td>Prior authorization required</td>
</tr>
<tr>
<td>EPSDT Special Services</td>
<td>For members less than 21 years old (excludes KCHIP Phase III)</td>
<td>See Comments</td>
<td>Prior authorization required for any service that exceeds benefit limit or is otherwise noted on this PA list. The services must be provided by a provider enrolled in the EPSDT Special Services program.</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Includes well woman exams, screenings, pregnancy testing, prescription birth control pills, Mirena, and other Intra-Uterine Devices (IUDs).</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>FQHC &amp; RHC Services</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Genetic Testing</td>
<td></td>
<td>Yes</td>
<td>Prior authorization required: CPT codes: 83890-83814; 88230-88299; 88384-88386; and ‘S’ codes indicating genetic testing.</td>
</tr>
<tr>
<td>Hearing Aids and Batteries</td>
<td>Limited to $800/ear every 36 months for members less than 21 years old. Batteries limited to 4 per instrument when billed with new or replacement instrument.</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>High Tech Imaging</td>
<td></td>
<td>Yes</td>
<td>Prior authorization required for CT, MRA, MRI, PET Scan</td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td></td>
<td>Yes</td>
<td>Prior authorization required for services including but not limited to: Skilled nursing services / Home health aide Home physical, occupational or speech therapy Home infusions / Wound therapy</td>
</tr>
<tr>
<td>Hospice Care (non-institutional)</td>
<td></td>
<td>Yes</td>
<td>Prior authorization required. Must submit signed copy of MD’s Certificate of Need</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td></td>
<td>Yes</td>
<td>Prior authorization required for Elective/Scheduled admissions and rehab admissions. Urgent/Emergent and</td>
</tr>
<tr>
<td>Service</td>
<td>Benefit Limitation</td>
<td>Prior Authorization</td>
<td>Comments</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------</td>
<td>---------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Hysterectomy</strong></td>
<td></td>
<td>Yes</td>
<td>Prior authorization required. Must submit form MAP 251: Hysterectomy Consent with Claim</td>
</tr>
<tr>
<td><strong>Laboratory Services</strong></td>
<td>No</td>
<td></td>
<td>Only Genetic Testing as noted above</td>
</tr>
<tr>
<td><strong>Maternity Care Services</strong></td>
<td>No</td>
<td></td>
<td>Submit Notice of Pregnancy (NOP) form at first visit.</td>
</tr>
<tr>
<td><strong>Neuro-Psychological Services</strong></td>
<td>Yes</td>
<td></td>
<td>Prior authorization required for codes: 96118, 96119, 96120</td>
</tr>
<tr>
<td><strong>OB Ultrasound</strong></td>
<td>See Comments</td>
<td>2 allowed in 9 months. Prior authorization required for additional u/s except if ordered by perinatologist.</td>
<td></td>
</tr>
<tr>
<td><strong>Observation</strong></td>
<td>See Comments</td>
<td>Notification required for hospital observation admission within 1 business day of admission.</td>
<td></td>
</tr>
<tr>
<td><strong>Oral Surgeon Services</strong></td>
<td>Yes</td>
<td></td>
<td>Prior authorization required for procedures conducted by Oral Surgeon</td>
</tr>
<tr>
<td><strong>Orthotics &amp; Prosthetics (O&amp;P)</strong></td>
<td>See Comments</td>
<td>Prior authorization required for items: Rental Items with purchase price of ≥ $500, Rental items with rental ≥ $250 if no purchase price, Purchase Items with purchase price of ≥ $500</td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Network Physician &amp; Facility</strong></td>
<td>Yes</td>
<td>Prior authorization required for all out of network provider/facility. EXCLUDES emergency room (ER) services, family planning services, routine labs and table top x-rays</td>
<td></td>
</tr>
<tr>
<td><strong>Pain Management Services</strong></td>
<td>Yes</td>
<td></td>
<td>Prior authorization required for services, including pain/nerve blocks, epidural injections, neuro-stimulators (both in office and outpatient)</td>
</tr>
<tr>
<td><strong>Physician, Physician Assistant, and Nurse Practitioner Office Visits</strong></td>
<td>No</td>
<td>See Out-of-Network</td>
<td></td>
</tr>
<tr>
<td><strong>Plastic Surgeon</strong></td>
<td>Yes</td>
<td></td>
<td>Prior authorization required for all treatments &amp; procedures in office or outpatient setting. Services for cosmetic purposes are not a covered benefit.</td>
</tr>
<tr>
<td><strong>Podiatrist Services</strong></td>
<td>Routine foot care is only covered for certain medical conditions.</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>Adults 19 and over - limit 4 prescriptions/ month with maximum 3 brand name drugs. Some exceptions apply.</td>
<td>Yes</td>
<td>Prior authorization required for specific medications as noted in the Preferred Drug List (PDL). See Specialty Injections. Services administered by US Script.</td>
</tr>
<tr>
<td><strong>Procedures/Surgery</strong></td>
<td>See Comments</td>
<td>Prior authorization required for the following services: Bariatric surgery, Blephroplasty, Breast reconstruction, Breast reduction, Mammaplasty, Otoplasty, Rhinoplasty, Varicose Vein treatments. *All other potentially cosmetic services</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Benefit Limitation</td>
<td>Prior Authorization</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------------------------------------</td>
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<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Pulmonary Rehab Services</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology and x-rays</td>
<td>See Comments</td>
<td>Prior authorization required for high-tech radiology including CT, MRI, MRA, PET. Services administered by National Imaging Associates (NIA). No PA required for routine x-rays. See OB Ultrasound.</td>
<td></td>
</tr>
<tr>
<td>Sleep Study</td>
<td>Yes</td>
<td>Prior authorization is required for study in outpatient or home setting</td>
<td></td>
</tr>
<tr>
<td>Specialty Injection and/or Infusion Services</td>
<td>See Comments</td>
<td>Prior authorization is required for select Biopharmaceuticals. See listing on the Kentucky Spirit website.</td>
<td></td>
</tr>
<tr>
<td>Stereotactic Radiosurgery</td>
<td>Yes</td>
<td>Prior authorization is required</td>
<td></td>
</tr>
<tr>
<td>Sterilization Procedures</td>
<td>No</td>
<td>Must submit form MAP 250: Consent for Sterilization with Claim.</td>
<td></td>
</tr>
<tr>
<td>Therapy (OT, PT, ST) Services (Outpatient)</td>
<td>Yes</td>
<td>Prior authorization required after Initial evaluation. Submit treatment plan &amp; goals for continued services. Must bill with appropriate G modifiers.</td>
<td></td>
</tr>
<tr>
<td>Transplant Service</td>
<td>Yes</td>
<td>Prior authorization required for all transplant services including transplant evaluation, pre and post services.</td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>No</td>
<td>Place of Service/Location = 20</td>
<td></td>
</tr>
<tr>
<td>Vision Services and Eyewear</td>
<td>One eye exam per calendar year for adults and children. Eyewear is limited to children under 21 years old.</td>
<td>See Comments</td>
<td>Prior authorization required for select non-routine services. Services administered by OptiCare.</td>
</tr>
</tbody>
</table>

Note: Members who are “presumptive eligibles” due to pregnancy are limited to the following covered services. The services must be related to pregnancy: office visits, x-rays, labs, emergency room visits, home health nursing (requires PA), emergency transportation, dental services, non emergency transportation services and pharmacy.

**Kentucky Spirit Health Plans Non-Covered Services**

<table>
<thead>
<tr>
<th>Non-Covered Services</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any laboratory service performed by a provider without current certification in accordance with Clinical Laboratory Improvement Amendment (CLIA)</td>
<td>This requirement applies to all facilities and individual providers of any laboratory service</td>
</tr>
<tr>
<td>Cosmetic procedures or services performed solely to improve appearance</td>
<td></td>
</tr>
<tr>
<td>Hysterectomy procedures, if performed for hygienic reasons or for sterilization only</td>
<td></td>
</tr>
<tr>
<td>Medical or surgical treatment of infertility (e.g., the reversal of sterilization invitro fertilization, etc.)</td>
<td></td>
</tr>
<tr>
<td>Induced abortion and miscarriage performed</td>
<td></td>
</tr>
<tr>
<td>Non-Covered Services</td>
<td>Comments</td>
</tr>
<tr>
<td>----------------------</td>
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</tr>
<tr>
<td>Any laboratory service performed by a provider without current certification in accordance with Clinical Laboratory Improvement Amendment (CLIA)</td>
<td>This requirement applies to all facilities and individual providers of any laboratory service</td>
</tr>
<tr>
<td>out-of-compliance with Federal and Kentucky laws and judicial opinions</td>
<td></td>
</tr>
<tr>
<td>Paternity testing</td>
<td></td>
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<tr>
<td>Personal service or comfort items</td>
<td></td>
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<tr>
<td>Post mortem services</td>
<td></td>
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<tr>
<td>Services, including but not limited to drugs, that are investigational, mainly for research purposes or experimental nature</td>
<td></td>
</tr>
<tr>
<td>Sex transformation services</td>
<td></td>
</tr>
<tr>
<td>Sterilization of a mentally incompetent or institutional member</td>
<td></td>
</tr>
<tr>
<td>Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid program regulations referenced herein</td>
<td></td>
</tr>
<tr>
<td>Services for which the Member has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage</td>
<td></td>
</tr>
<tr>
<td>Services for substance abuse diagnoses in adults except for pregnant women, or in cases where acute care physical health services related to substance abuse or detoxification are necessarily required</td>
<td></td>
</tr>
<tr>
<td>Services provided in countries other than the United States</td>
<td>Unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services</td>
</tr>
</tbody>
</table>

**MEDICAL MANAGEMENT**

**Overview and Medical Necessity**

Kentucky Spirit Health Plans’ Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., EST (excluding holidays). After normal business hours NurseWise representatives are available to answer questions about authorization requirement. Medical Management services include the areas of utilization management, case management, disease management, and quality review. The department clinical services are overseen by the Kentucky Spirit Health Plan medical director (“Medical Director”). The VP of Medical Management has responsibility for direct supervision and operation of the department. To reach the Medical Director or VP of Medical Management contact:

Utilization Management 1-866-643-3153
Referrals – As promoted by the Medical Home concept, PCPs should coordinate most of the healthcare services for Kentucky Spirit Health Plan members. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP’s training or practice parameters; however, paper referrals are not required. To better coordinate a members’ healthcare, Kentucky Spirit Health Plan encourages specialists to communicate to the PCP the need for a referral to another specialist rather than making such a referral themselves.

Notifications - A provider is required to promptly notify Kentucky Spirit Health Plan when prenatal care is rendered. Early notification of pregnancy allows the health plan to assist the member with prenatal care coordination of services.

Prior Authorizations - Some services require prior authorization from Kentucky Spirit Health Plan in order for reimbursement to be issued to the provider. All out-of-network services require prior authorization. To verify whether a prior authorization is necessary or to obtain a prior authorization, call:

**Kentucky Spirit Health Plan**  
**Medical Management/Prior Authorization Department**  
Telephone 1-866-643-3153  
Fax 1-855-252-0567  
www.KentuckySpiritHealth.com

Prior authorization requests may be done electronically on our Provider Portal (using the ANSI X 12N 278 transaction code specifications). For more information on filing prior authorizations via our Portal, or any other questions regarding the Provider Portal, please contact your Provider Relations Representative.

Utilization Management

Kentucky Spirit Health Plans’ Utilization Management Program (UMP) is designed to ensure members of Kentucky Managed Care Organization receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long term care, and ancillary care services.

Kentucky Spirit Health Plans’ UMP seeks to optimize a member's health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Our program goals include:

- Monitoring utilization patterns to guard against over- or under- utilization
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
• Identification and provision of intensive care and/or disease management for members at risk for significant health expenses or ongoing care
• Development of an infrastructure to ensure that all Kentucky Spirit Health Plan members establish relationships with their PCPs to obtain preventive care
• Implementation of programs that encourage preventive services and chronic condition self-management
• Creation of partnerships with members/providers to enhance cooperation and support for UMP goals

**Second Opinion**
Members or a healthcare professional with the member’s consent may request and receive a second opinion from a qualified professional within the Kentucky Spirit Health Plan network related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider. Out-of-network providers will require prior authorization by Kentucky Spirit Health Plan.

**Assistant Surgeon**
Reimbursement for an assistant surgeon’s service is based on the medical necessity of the procedure itself and the assistant surgeon’s presence at the time of the procedure. Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

**Clinical Information**
Authorization requests may be submitted by fax, phone or secure web portal. Authorization determinations may be communicated to the provider fax, phone, secure email, or secure web portal. Adverse determinations will be followed up in writing. A referral specialist will enter the demographic information and transfer the information to a Kentucky Spirit Health Plan nurse for the completion of medical necessity screening. For all services on the prior authorization list, documentation supporting medical necessity will be required.

Kentucky Spirit Health Plan clinical staff will request clinical information that is minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Kentucky Spirit Health Plan is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations.

Information necessary for authorization of covered services may include but is not limited to:

- Member’s name, member ID number
- Provider's name and telephone number
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g., primary and secondary diagnoses, planned surgical procedures, surgery date)
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Discharge plans

Notification of newborn deliveries should include the mother’s name, date of delivery, method of delivery, and weight.

If additional clinical information is required, a Kentucky Spirit Health Plan nurse or medical management representative will notify the caller of the specific information needed to complete the authorization process.

**Clinical Decisions**

Kentucky Spirit Health Plan affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. Kentucky Spirit Health Plan does not reward practitioners or other individuals for issuing denials of service or care.

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the Kentucky Spirit Health Plan Medical Director, is responsible for making utilization management (UM) decisions in accordance with the member’s plan of covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

**Medical Necessity**

Medical necessity is defined for Kentucky Spirit Health Plan members as healthcare services, supplies or equipment provided by a licensed healthcare professional that are:

- Appropriate and consistent with the diagnosis or treatment of the patient’s condition, illness, or injury
- In accordance with the standards of good medical practice consistent with evidence based and clinical practice guidelines
- Not primarily for the personal comfort or convenience of the member, family, or provider
- The most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the member
- Furnished in a setting appropriate to the patient’s medical need and condition and, when supplied to the care of an inpatient, further mean that the member’s medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient service
- Not experimental or investigational or for research or education

**Review Criteria**

Kentucky Spirit Health Plan has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual
appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the member’s condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 1-866-643-3153. Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted by calling Kentucky Spirit Health Plans’ main toll-free phone number and asking for the Medical Director. A case manager may also coordinate communication between the Medical Director and requesting practitioner.

Members or healthcare professionals, with the member’s consent, may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

Kentucky Spirit Health Plan
Grievance and Appeals Coordinator
201 East Main Street
Lexington, Kentucky 40507
1-866-643-3153
Fax 1-877-851-3995

New Technology
Kentucky Spirit Health Plan evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the Kentucky Spirit Health Plan population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department 1-866-643-3153.

Prior Authorization and Notifications
Prior authorization is a request to the Kentucky Spirit Health Plan UM department for approval of services on the prior authorization list before the service is delivered. Authorization must be obtained prior to the delivery of certain elective and scheduled services. Services that require authorization by Kentucky Spirit Health Plan are listed in the Authorization Table beginning on page 18. The PCP should contact the UM department via telephone, fax or through our website with appropriate supporting clinical information to
request an authorization. All out-of-network services require prior authorization and will require Kentucky Spirit Health Plan Medical Director to review and approve.

Emergency Room (ER)/urgent care services never require prior authorization. Providers should notify Kentucky Spirit Health Plan of post-stabilization services such as but not limited to the weekend or holiday provision of home health, durable medical equipment, or urgent outpatient surgery, within one business day of the service initiation. Clinical information is required for ongoing care authorization of the service.

Failure to obtain authorization may result in administrative claim denials. Kentucky Spirit Health Plan providers are contractually prohibited from holding any Kentucky Spirit Health Plan member financially liable for any service administratively denied by Kentucky Spirit Health Plan for the failure of the provider to obtain timely authorization.

Authorization Determination Timelines
Kentucky Spirit Health Plans’ decisions are made as expeditiously as the member’s health condition requires. “Necessary information” includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information can result in an administrative denial of the requested service. For urgent/expedited pre-service requests, a decision and notification is made two business days of the receipt of the request.

Notification of Pregnancy
If a member becomes pregnant while covered by Kentucky Spirit Health Plan the managing physician should notify the Kentucky Spirit Health Plan prenatal team by completing the Notification of Pregnancy (NOP) form within five days of the first prenatal visit. Providers are expected to identify the estimated date of confinement and delivery facility. See the Case Management section for information related to our Start Smart for Your Baby® Program and our 17-P Program for women with a history of early delivery.

Concurrent Review and Discharge Planning
Nurse Case Managers perform ongoing concurrent review for inpatient admissions through onsite or telephonic methods through contact with the hospital’s Utilization and Discharge Planning departments and when necessary, with the member’s attending physician. The Case Manager will review the member’s current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within 24 hours of receipt of the request. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or c-section deliveries do not require concurrent review, however; the hospital must notify Kentucky Spirit Health Plan within two business days of delivery with complete information regarding the delivery status and condition of the newborn. Service beyond 48 hours for vaginal delivery or 96 hours for a cesarean will require concurrent review.

Retrospective Review
Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to Kentucky Spirit Health Plan was not obtained
due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have their Medicaid card or otherwise indicated Medicaid coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within 30 calendar days following receipt of the request (not to exceed 180 calendar days from the date of service).

**PHARMACY**

**Pharmacy Program**

Kentucky Spirit Health Plan is committed to providing appropriate, high quality, and cost effective drug therapy to all Kentucky Spirit Health Plan members. Kentucky Spirit Health Plan works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. Kentucky Spirit Health Plan covers prescription medications and certain over-the-counter (OTC) medications when ordered by a Kentucky Spirit Health Plan physician/clinician. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage, and maximum quantities.

This section provides an overview of the Kentucky Spirit Health Plan pharmacy program. For more detailed information, please visit our website at [www.KentuckySpiritHealth.com](http://www.KentuckySpiritHealth.com) or contact us at 1-866-643-3153.

**Preferred Drug List**

The Kentucky Spirit Health Plan Preferred Drug List (PDL) is the list of covered drugs. The PDL applies to drugs the member receives at retail pharmacies. The Kentucky Spirit Health Plan PDL is continually evaluated by the Kentucky Spirit Health Plan Pharmacy and Therapeutics (P&T) Committee to promote the appropriate and cost-effective use of medications. The Committee is composed of the Kentucky Spirit Health Plan Medical Director, Kentucky Spirit Health Plan Pharmacy Program Director, and several Kentucky primary care physicians and specialists. A copy of our Provider Drug List may be obtained through our website at [www.KentuckySpiritHealth.com](http://www.KentuckySpiritHealth.com) or by calling our Provider Service Department at 1-866-643-3153.

**Pharmacy Benefit Manager**

Kentucky Spirit Health Plan works with US Script to process all pharmacy claims for prescribed drugs. Some drugs on the Kentucky Spirit Health Plan PDL require a PA and US Script is responsible for administering this process. US Script is our Pharmacy Benefit Manager.

**Biopharmaceuticals**

Kentucky Spirit Health Plan provides a number of biopharmaceutical products through the Biopharmaceutical Program. Most biopharmaceuticals and injectables billed for more than $250 require a PA to be approved for payment by Kentucky Spirit Health Plan; however, PA requirements are programmed specific to the drug as indicated in the list provided in the Biopharmaceutical Program document located on the Kentucky Spirit Health Plan website at [www.KentuckySpiritHealth.com](http://www.KentuckySpiritHealth.com).
**Prescription Limits**

In general, members age 19 and above may get up to four prescriptions per 26 days. No more than three of the four prescriptions may be name brand products, including refills.

Children under 19 years of age may get more than three brand name prescriptions per 26 days. Insulin products (defined by Drug Category Code “I” and route of administration is intravenous, intramuscular, injection, intradermal, or subcutaneous) are exempt from the three name brand prescription limitation. If the member’s three brand prescription limit has been exceeded, and the prescription, in the pharmacist’s professional judgment, is for a life threatening medical condition that, if medication is not dispensed, could result in hospitalization or place the member in jeopardy, the pharmacist can provide additional brand name products.

Children under 19 years of age may get more than four prescriptions per 26 days. Insulin products (defined by Drug Category Code “I” and route of administration is intravenous, intramuscular, injection, intradermal, or subcutaneous) are exempt from the four prescription limitation. If the member has one or more of the following medical conditions the four prescription limitation is not applicable:

- Acute therapy for migraine headaches/acute pain
- Acute infections/infestations
- Bipolar disorders
- Cancer
- Cardiac rhythm disorders
- Chronic pain
- Coronary artery/cerebrovascular disease (advanced artherosclerotic disease)
- Cystic fibrosis
- Dementia
- Diabetes
- End stage lung disease
- End stage renal disease
- Epilepsy
- Hemophilia
- HIV/AIDS/Immunocompromised
- Hyperlipidemia
- Hypertension
- Major depression
- Metabolic syndrome
- Organ transplant
- Psychotic disorders
- Schizophrenic disorders
- Schizotypal personality disorders
- Suppressive therapy for thyroid cancer
- Terminal state of an illness

The four prescription limitation is not applicable for following therapeutic classes/medications:

- Alpha 1-Proteinase
- Alzheimer’s agents
- Antibiotics
- Antipsychotics
- Anti-Parkinson agents
- Anti-Tuberculosis agents
- Anti-Viral medications
- Asthma/COPD agents
- Cancer agents
- Cardiovascular agents
- Clotting Factors/Antiplatelet
- Contraceptives
- Diabetes agents
- Dialysis
- Folic Acid
- Hematopoietic agents
- Large Volume Parenterals
- Lipotropics
- Monoclonal Antibodies
- Multiple Sclerosis agents
- Prenatal vitamins
- Pulmonary Hypertension agents
- Thyroid agents
- Total Parenteral Nutrition
- Transplant agents
- Thalomid
- Xolair

**Dispensing Limits**

Drugs may be dispensed up to a maximum of 32 days supply for each new prescription or refill. A total of 85% of the days supply must have elapsed before the prescription can be refilled for all drugs (non-controlled-substances, controlled-substances, and narcotic drugs).

**Appropriate Use and Safety Edits**

The health and safety of our members is a priority for Kentucky Spirit Health Plan. One of the ways we address patient safety is through point-of-sale (POS) edits at the time a prescription is processed at the pharmacy. These edits are based on FDA recommendations and promote safe and effective medication utilization.

Additional information about the drugs that are part of the Appropriate Use and Safety Edits can be found in the Appropriate Use and Safety Edits document located on the Kentucky Spirit Health Plan website at [www.KentuckySpiritHealth.com](http://www.KentuckySpiritHealth.com).

**Prior Authorizations**

Some medications listed on the Kentucky Spirit Health Plan PDL may require PA. The information should be submitted by the physician/clinician to US Script on the Medication Prior Authorization Form. This form should be faxed to US Script at 1-866-399-0929. This document is located on the Kentucky Spirit Health Plan website at [www.KentuckySpiritHealth.com](http://www.KentuckySpiritHealth.com).

Kentucky Spirit Health Plan will cover the medication if it is determined that:
1. There is a medical reason the member needs the specific medication.
2. Depending on the medication, other medications on the PDL have not worked.
All reviews are performed by a licensed clinical pharmacist using the criteria established by the Kentucky Spirit Health Plan P&T Committee. Once approved, US Script notifies the physician/clinician by fax. If the clinical information provided does not meet the coverage criteria for the requested medication Kentucky Spirit Health Plan we will notify the member and the physician/clinician of alternatives and provide information regarding the appeal process.

**Step Therapy**

Some medications listed on the Kentucky Spirit Health Plan PDL may require specific medications to be used before a member can receive the step therapy medication. If Kentucky Spirit Health Plan has a record that the required medication was tried first the step therapy medications are automatically covered. If Kentucky Spirit Health Plan does not have a record that the required medication was tried, the member or physician/clinician may be required to provide additional information. If Kentucky Spirit Health Plan does not grant PA we will notify the member and their physician/clinician and provide information regarding the appeal process.

**Quantity Limits**

Kentucky Spirit Health Plan may limit how much of a medication a member can get at one time. If the physician/clinician feels the member have a medical reason for getting a larger amount, he or she can ask for PA. If Kentucky Spirit Health Plan does not grant PA we will notify the member and the physician/clinician and provide information regarding the appeal process.

**Age Limits**

Some medications on the Kentucky Spirit Health Plan PDL may have age limits. These are set for certain drugs based on FDA approved labeling and for safety concerns and quality standards of care. Age limits align with current FDA alerts for the appropriate use of pharmaceuticals.

**Gender Limits**

Some medications on the Kentucky Spirit Health Plan PDL may be limited to one gender. These medications have a GL after them on the PDL. These limits are set for certain drugs based on FDA approved labeling and for safety concerns and quality standards of care. Gender limits align with current FDA alerts for the appropriate use of pharmaceuticals.

**Medical Necessity Requests**

If the member requires a medication that does not appear on the PDL, the member of physician/clinician can make a medical necessity request for the medication. It is anticipated that such exceptions will be rare and that PDL medications will be appropriate to treat the vast majority of medical conditions. Kentucky Spirit Health Plan requires:

- Documentation of failure of at least two PDL agents within the same therapeutic class (provided two agents exist in the therapeutic category with comparable labeled indications) for the same diagnosis (e.g. migraine, neuropathic pain, etc.); or
- Documented intolerance or contraindication to at least two PDL agents within the same therapeutic class (provided two agents exist in the therapeutic category with comparable labeled indications); or
• Documented clinical history or presentation where the patient is not a candidate for any of the PDL agents for the indication.

All reviews are performed by a licensed clinical pharmacist using the criteria established by the Kentucky Spirit Health Plan Pharmacy and Therapeutics Committee. If the clinical information provided does not meet the coverage criteria for the requested medication Kentucky Spirit Health Plan will notify the member and the physician/clinician of alternatives and provide information regarding the appeal process.

72-Hour Emergency Supply Policy
State and Federal law require that a pharmacy dispense a 72-hour (3-day) supply of medication to any patient awaiting a PA determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour supply of medication, whether or not the PA request is ultimately approved or denied. The pharmacy must call the US Script Pharmacy Help Desk at 877-285-8489 for a prescription override to submit the 72-hour medication supply for payment.

Exclusions
The following drug categories are not part of the Kentucky Spirit Health Plan PDL and are not covered by the 72-hour emergency supply policy:
• DESI, IRS, or LTE drugs
• Diagnostics
• Supplies
• Non-rebatable products except for covered vitamins and vaccines
• Herbals
• Blood/blood plasma products
• Topical contraceptives
• Nutritional/dietary supplements
• Drugs used for anorexia, weight loss, or weight gain
• Drugs used to promote fertility
• Drugs used for cosmetic purposes
• Vitamin or mineral products other than prenataals or fluoride preparations (fluoride not covered over age 16)
• Mifeprax
• Drugs to treat impotency
• Lice bedding spray
• Miscellaneous diagnostic preps
• Biologicals (except Antisera)
• Bulk chemicals excipients

Newly Approved Products
We review new drugs for safety and effectiveness before adding them to the Kentucky Spirit Health Plan PDL. During this period, access to these medications will be considered through the PA review process. If Kentucky Spirit Health Plan does not grant PA we will notify the member and physician/clinician and provide information regarding the appeal process.
**Over-the-Counter Medications**

The Kentucky Spirit Health Plan PDL covers a variety of OTC medications. A list of covered OTC medications can be found in the Over-the-Counter Medications section of the PDL. Kentucky Spirit Health Plan PDL OTCs are covered when a member has a prescription from a licensed physician/clinician that meets all the legal requirements for a prescription.

**Tobacco Cessation Medications**

The following types of tobacco cessation medications will be covered by Kentucky Spirit Health Plan: generic nicotine replacement products (gum, lozenges, and patches), Bupropion Hydrochloride, and Varenicline Tartrate (Chantix). A physician/clinician prescription will be required for all tobacco cessation medications. Each prescription will count toward the monthly limit. There are no co-pays for covered products.

Kentucky Spirit Health Plan authorizes benefits for tobacco cessation medications for the purpose of supporting members who are trying to quit tobacco use with the temporary assistance of nicotine replacement therapy. It is expected that utilization of these products will be in accordance with medical standards of practice, FDA guidelines, and manufacturers’ recommendations which generally limit product use to approximately 12 weeks.

**Generic Drugs**

When generic drugs are available, the brand-name drug will not be covered without prior Kentucky Spirit Health Plan authorization. Generic drugs have the same active ingredient, work the same as brand-name drugs, and have lower co-payments. If the member and the physician/clinician feel a brand-name drug is medically necessary, the physician/clinician can ask for PA. We will cover the brand-name drug according to our clinical guidelines if there is a medical reason the member needs the particular brand-name drug. If Kentucky Spirit Health Plan does not grant PA we will notify the member and the physician/clinician and provide information regarding the appeal process.

The provision is waived for the following products due to their narrow therapeutic index (NTI) as recognized by current medical and pharmaceutical literature: Aminophylline, Amiodarone, Carbamazepine, Clozapine, Cyclosporine, Digoxin, Disopyramide, Ethosuximide, Flecainide, L-thyroxine, Lithium, Phenytoin, Procainamide, Propafenone, Theophylline, Thyroid, Valproate Sodium, Valproic Acid, and Warfarin.

**Filling a Prescription**

Members can have prescriptions filled at a Kentucky Spirit Health Plan network pharmacy. If a member decides to have a prescription filled at a network pharmacy they can locate a pharmacy near them by contacting a Kentucky Spirit Health Plan Member Services Representative. At the pharmacy the member will need to provide the pharmacist with their prescription and their Kentucky Spirit Health Plan ID card.

**Maintenance Drug Program**

Members can have a 92 day supply (3 month supply) or 100 units, whichever is greater, of maintenance medications filled at one time. Maintenance medications are used to treat long-term conditions or illnesses. Additional information about the drugs that are part of the

BEHAVIORAL HEALTH SERVICES

Kentucky Spirit Health Plan offers members access to all medically-necessary behavioral health services covered by the Kentucky Medicaid program. Cenpatico is a sister company of Kentucky Spirit Health Plan and is the behavioral health vendor for all Kentucky Spirit Health Plan members. Kentucky Spirit Health Plan members may self-refer to any outpatient behavioral health services offered through Community Mental Health Centers (CMHCs) certified as Medicaid providers by the Cabinet for Health and Family Services (CHFS) and contracted with Cenpatico.

A list of Cenpatico’s contracted inpatient and outpatient providers and further information about Cenpatico’s inpatient and outpatient medical necessity criteria policies and procedures can be obtained by calling Cenpatico Customer Service at 1-855-730-5056 or by going online to: www.cenpatico.com.

Additionally in collaboration with Kentucky Spirit Health Plan, Cenpatico offers intensive case management and care coordination services to members to assist them with accessing behavioral health care, adhering to behavioral health treatment recommendations, and maintaining tenure in the community. Kentucky Spirit Health Plan and Cenpatico encourage medical providers and behavioral health providers to exchange information to ensure the most inclusive coordination of care for Kentucky Spirit Health Plan members. Cenpatico Intensive Case Managers and Care Coordinators work with both members’ PCPs and behavioral health providers on this coordination of care. Cenpatico Intensive Case Managers and Care Coordinators are available for assistance with discharge planning and for following-up with members after discharge from a behavioral health admission. To request assistance from an Intensive Case Manager or Care Coordinator, contact Cenpatico Customer Service at 1-855-730-5056.

SPEECH THERAPY AND REHABILITATION SERVICES

Kentucky Spirit Health Plan offers our members access to all covered, medically necessary outpatient physical, occupational and speech therapy services through Cenpatico, Specialty Therapy and Rehabilitative Services (STRS). Specialty Therapy and Rehabilitative Services include occupational, physical and speech therapy.

Kentucky Spirit Health Plan members seeking occupational, physical or speech therapy services on an outpatient basis should submit prior authorization requests for outpatient physical, occupational and speech therapy services using the Outpatient Treatment Request (OTR) form to Cenpatico.

Cenpatico STRS Outpatient Therapies Prior Authorization
All requests for Speech, Occupational and Physical Outpatient Therapy should be submitted using the STRS OTR form located at www.KentuckySpiritHealth.com or www.Cenpatico.com. All therapies occurring in an inpatient setting will be authorized by Kentucky Spirit Health Plan.

In the event that the practitioner is unable to provide timely access for a member, Cenpatico will assist in securing authorization to a practitioner to meet the member’s needs in a timely manner.

For more detailed information, please visit our website at www.KentuckySpiritHealth.com or www.cenpatico.com.

Cenpatico created and applies medical necessity criteria developed using Clinical Practice Guidelines of the physical, occupational and speech Professional Associations, as well as InterQual Criteria for both Adults and Pediatrics guidelines. InterQual is a nationally recognized instrument that provides a consistent, evidence-based platform for care decisions and promotes appropriate use of services and improved health outcomes.

Cenpatico criteria can be found on the Cenpatico website at: www.Cenpatico.com. Cenpatico is committed to the delivery of appropriate service and coverage, and offers no organizational incentives, including compensation, to any employed or contracted Utilization Management (UM) staff based on the quantity or type of utilization decisions rendered. Review decisions are based only on appropriateness of care and service criteria, and UM staff is encouraged to bring inappropriate care or service decisions to the attention of the Medical Director.

Cenpatico utilizes Occupational, Physical and Speech Therapists to process Outpatient Treatment Request. Cenpatico’s specialized approach allows for interaction in real time with the provider to best meet the overall therapeutic needs of the members.

**CARE COORDINATION FOR SPECIALTY THERAPY AND REHABILITATIVE SERVICE**

Cenpatico’s STRS case management model uses an integrated team of, licensed rehabilitation professionals and non-clinical staff. The model is designed to help members obtain needed services and assist them in coordination of their healthcare needs whether they are covered within the Kentucky Spirit Health Plan array of covered services, from the community, or from other non-covered venues. We recognize that multiple co-morbidities will be common among our membership. The goal of our program is to collaborate with the member and all treating providers to assist our members to achieve the highest possible levels of wellness, functioning, and quality of life.

The program includes a systematic approach for early identification of members’ needs through screening and assessment. In partnership with our members, we will develop and implement an individualized care plan that is comprehensive and will incorporate the full range of needed services we identify with our members. Our teams will engage members to be fully participatory in their health decisions and offer education as well as support for achieving member goals. Care plans will be shared with treating providers and our Care Coordinators will serve to facilitate exchange of information between providers and with members.
We look forward to hearing from you about any Kentucky Spirit Health Plan members you think can benefit from outreach by a Kentucky Spirit Health Plan Care Coordinator.

To contact a care coordinator, please call the Cenpatico at 1-855-790-5056.

HI TECH RADIOLOGY SERVICES

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our members, Kentucky Spirit Health Plan is using National Imaging Associates (NIA) to provide prior authorization services and utilization. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT / CTA
- MRI / MRA
- PET Scan

KEY PROVISIONS:
- Emergency room, observation and inpatient imaging procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

To reach NIA and obtain authorization, please call 1-800-218-7508 and follow the prompt for radiology authorizations. NIA also provides an interactive website which may be used to obtain on-line authorizations. Please visit www.RadMD.com for more information or call our Provider Services department.

EPSDT

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service (Kentucky KIDMED) is Medicaid’s comprehensive and preventive child health program for individuals under the age of 21, provision of which is mandated by state and federal law. EPSDT services include periodic screening, vision dental and hearing services. In addition, the need for corrective treatment disclosed by such child health screenings must be arranged (directly or through referral) even if the service is not available under the State’s Medicaid plan to the rest of the Medicaid population.

Kentucky Spirit Health Plan and its providers will provide the full range of EPSDT services as defined in, and in accordance with, Kentucky state regulations and States policies and procedures for EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up to date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended
immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventative care. This includes provision of all medically necessary services whether specified in the core benefits and services or not, except those services (carved out/excluded/prohibited services) that have been identified herein. The following minimum elements are to be included in the periodic health screening assessment:

(a) Comprehensive health and development history (including assessment of both physical and mental development);  
(b) Comprehensive unclothed physical examination;  
(c) Immunizations appropriate to age and health history;  
(d) Assessment of nutritional status;  
(e) Laboratory tests (including finger stick hematocrit, urinalysis (dip-stick), sickle cell screen, TB skin testing and RPR serology if not previously performed); Blood lead levels must be tested pursuant to the EPSDT provider manual.  
(f) Developmental assessment  
(g) Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses;  
(h) Dental screening and services  
(i) Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids; and  
(j) Health education and anticipatory guidance.  

Provision of all components of the EPSDT service must be clearly documented in the PCP’s medical record for each member.  

Kentucky Spirit Health Plan requires that providers cooperate to the maximum extent possible with efforts to improve the health status of Kentucky citizens, and to actively participate in the increase of percentage of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules. Kentucky Spirit Health Plan will cooperate and assist providers to identify and immunize all members whose medical records do not indicate up-to-date immunizations.  

Provider shall participate in the Vaccines for Children (VFC) program. Vaccines must be billed with the appropriate administration code and the vaccine detail code.  

VALUE ADDED SERVICES  

NurseWise  
NurseWise is our 24 hour, seven day per week nurse line for members. Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency access through the NurseWise service. Our staff often answers basic health
questions, but is also available to triage more complex health issues using nationally-recognized protocols. Members with chronic problems, like asthma or diabetes are referred to case management for education and encouragement to improve their health.

Members may use NurseWise to request information about providers and services available in the community after hours, when the Kentucky Spirit Health Plan Member Services department ("Member Services") is closed. The NurseWise staff is available in both English and Spanish and can provide additional translation services if necessary.

We provide this service to support your practice and offer our members access to a registered nurse at any time – day or night. If you have any additional questions, please contact Provider Services or NurseWise at 1-866-643-3153.

**CentAccount® Program**

The goal of the CentAccount program is to increase appropriate utilization of preventive services by rewarding members for practicing a targeted healthy behavior. The program will strengthen the relationship with the medical home as members regularly access preventive services, and will promote personal responsibility for and ownership of the member's own healthcare.

CentAccount also benefits members because it provides them with credits to purchase healthcare items that they might otherwise not be able to afford. Please go to [www.KentuckySpiritHealth.com](http://www.KentuckySpiritHealth.com) to locate the list of services that will qualify for reward.

**How does it work?** Members will receive a prepaid MasterCard® debit card. Credit will be added to the account balance once the member receives certain screenings or preventive care. Members may use the cards to purchase approved healthcare goods and services online or at more than 150 retailers that accept MasterCard Debit cards, such as Wal-Mart, Walgreens, Target, and CVS. CentAccount goods and services are those recognized by the Internal Revenue Service as healthcare expenses for flexible spending accounts.

**MemberConnections® Program**

**MemberConnections** is Kentucky Spirit Health Plans’ outreach program designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. The program components are integrated as a part of our case management program in order to link Kentucky Spirit Health Plan and the community served. The program recruits staff from the communities serviced to establish a grassroots support and awareness of Kentucky Spirit Health Plan within the community. The program has various components that can be provided depending on the need of the member.

Members can be referred to MemberConnections through numerous sources. Members who phone Kentucky Spirit Health Plan to talk with Kentucky Spirit Health Plans’ Member Services department may be referred for more personalized discussion on the topic they are inquiring about. Case managers may identify members who would benefit from one of the many MemberConnections components and complete a referral request. Providers may request MemberConnections referrals directly to the Connections Representative or their assigned case manager. Community groups may request that a Connections Representative
come to their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

**Community Connections:** Connection Representatives are available to present to group setting during events initiated by state entities, community groups, clinics, or any other approved settings. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what Medicaid coordinated care is all about, overview of services offered by Kentucky Spirit Health Plan, how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from providers and Kentucky Spirit Health Plan.

**Home Connections:** Connection Representatives are available on a full-time basis whenever a need or request from a member or provider arises. All home visits are pre-scheduled with the member unless the visit is a result of being unable to locate a member. Topics covered during a home visit include overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive healthcare, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation, and how to contact the health plan for assistance.

**Phone Connections:** Connection Representatives may contact new members or members in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered and any additional questions answered.

**Connections Plus®:** Connections Representatives work together with the case management team for high risk members who do not have safe, reliable phone access. When a member is identified by their PCP, a Connections Representative visits the member’s home and gives them a free, pre-programmed cell phone with limited use. Members may use this cell phone to call the health plan case manager, PCP, specialty physician, NurseWise, 911, or other members of their health care team.

To contact the MemberConnections Team call:
**Kentucky Spirit Health Plan**
**MemberConnections**
1-866-643-3153

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**CASE MANAGEMENT PROGRAM**

Kentucky Spirit Health Plans’ case management model is designed to help your Kentucky Spirit Health Plan members obtain needed services, whether they are covered within the Kentucky Spirit Health Plan array of covered services, from the community resources, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice or large multi-specialty group setting.

The program is based upon a coordinated care model that uses a multi-disciplinary case management team in recognition that a holistic approach yields better outcomes. The goal of our program is to help members achieve the highest possible levels of wellness, functioning, and quality of life, while decreasing the need for disruption at the PCP or specialist office with administrative work.
The program includes a systematic approach for early identification of eligible members, needs assessment, and development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP. Our case management team will integrate covered and non-covered services and provide a holistic approach to a member’s medical, as well as function, social and other needs and coordinates access to services not included in core benefit package such as behavioral health, dental and pharmacy services. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A case management team is available to help all providers manage their Kentucky Spirit Health Plan members. Listed below are programs and components of special services that are available and can be accessed through the case management team. We look forward to hearing from you about any Kentucky Spirit Health Plan members that you think can benefit from the addition of a Kentucky Spirit Health Plan case management team member.

To contact a case manager call:

Kentucky Spirit Health Plan  
Case Management Department  
1-866-643-3153  
Fax Line 1-855-252-0561

**High Risk Pregnancy Program**

The Obstetrics Care Management Team will implement our **Start Smart for Your Baby® Program** (Start Smart), which incorporates case management, care coordination, and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique perinatal program that follows women for up to one year after delivery and includes neonates and qualified children up to one year of age. The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing case management to high and moderate risk members through the postpartum period and infants through the first year of life. A case manager with obstetrical nursing experience will serve as lead case manager for members at high risk of early delivery or who experience complications from pregnancy. An experienced neonatal nurse will be the lead CM for newborns being discharged from the NICU unit and will follow them through the first year of life when they remain members. The OB/Neonate team has physician oversight advising the team on overcoming obstacles, helping identify high risk members, and recommending interventions. These physicians will provide input to Kentucky Spirit Health Plans’ Medical Director on obstetrical care standards and use of newer preventive treatments such as 17 alpha-hydroxyprogesterone caproate (17-P).

Kentucky Spirit Health Plan offers a premature delivery prevention program by supporting the use of 17-P. When a physician determines that a member is a candidate for 17-P, which use has shown a substantial reduction in the rate of preterm delivery, he/she will write a prescription for 17-P. This prescription is sent to the Kentucky Spirit Health Plan case manager who will check for eligibility. The case manager will coordinate the ordering and delivery of the 17-P directly to the physician’s office. A prenatal case manager will contact
the member and do an assessment regarding compliance. The nurse will remain in contact with the member and the prescribing physician during the entire treatment period. Contact the Kentucky Spirit Health Plan high risk pregnancy department for enrollment in the 17-P program.

**Complex Teams**

These teams will be led by clinical licensed nurses with either adult or pediatric expertise as applicable. For both adult and pediatric teams, staff will be familiar with evidence-based resources and best practice standards and experience with the population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services. The Kentucky Spirit Health Plan complex teams will manage care for members whose needs are primarily functional as well as those with such complex conditions as hemophilia, breast/cervical cancer, trauma, organ transplants, and renal dialysis. Foster care members and children with special healthcare needs are at special risk and are also eligible for enrollment in case management. Kentucky Spirit Health Plan will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better health care choices.

A **Transplant Coordinator** will provide support and coordination for members who need organ transplants. All members considered as potential transplant candidates should be immediately referred to the Kentucky Spirit Health Plan case management department for assessment and case management services. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.

**Chronic Care/Disease Management Programs**

As a part of Kentucky Spirit Health Plans’ services, Chronic Care Management Programs (CCMP) are offered to members. Chronic Care Management/Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care. Chronic care management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

**Nurtur**, Centene’s disease management subsidiary, will administer Kentucky Spirit Health Plans’ chronic care management program. Nurtur’s programs promote a coordinated, proactive, disease-specific approach to management that will improve members’ self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions. Kentucky Spirit Health Plans’ programs include but are not limited to: asthma, diabetes and congestive heart failure.

Not all members having the targeted diagnoses will be enrolled in the CCMP. Members with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk members with co-morbid or complex conditions will be referred for case management program evaluation.

To refer a member for chronic care management call:
Kentucky Spirit Health Plan
Kentucky Spirit Health Plans’ Provider Relations department is designed around the concept of making your experience a positive one by being your advocate within our health plan. The Provider Relations Department is responsible for providing the services listed below which include but are not limited to:

- Maintenance of existing Kentucky Spirit Health Plan Provider Manual
- Capitation distribution
- Eligibility distribution
- Researching of trends in claims inquiries to Kentucky Spirit Health Plan
- Network performance profiling
- Individual physician performance profiling
- Physician and office staff orientation
- Hospital and ancillary staff orientation
- Ongoing provider education, updates, and training

The goal of the department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to Kentucky Spirit Health Plan enrolled membership.

To contact the provider relations specialist for your area contact our Provider Services toll free help line at 1-866-643-3153. Provider Services Representatives work with Provider Relations Specialists to serve as your advocates to ensure that you receive necessary assistance and maintain satisfaction with Kentucky Spirit Health Plan.

**Top 10 Reasons to Contact a Provider Relations Representative**

1. To report any change to your practice (i.e. practice TIN, name, phone numbers, fax numbers, address, and addition or termination of providers, or patient acceptance.
2. Initiate credentialing of new providers.
3. To schedule an in-service training for new staff.
4. To conduct ongoing education for existing staff.
5. To obtain clarification of policies and procedures.
6. To obtain clarification of a provider contract.
7. To request fee schedule information.
8. To obtain responses to membership list questions.
9. To obtain responses to claims questions.
10. To learn how to use electronic solutions on web authorizations, claims submissions, and check eligibility.

**BILLING AND CLAIMS SUBMISSION**

**General Billing Guidelines**

Physicians, other licensed health professionals, facilities, and ancillary provider’s contract directly with Kentucky Spirit Health Plan for payment of covered services.
It is important that providers ensure Kentucky Spirit Health Plan has accurate billing information on file. Please confirm with your Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address

Providers must bill with their NPI number in box 24Jb. We encourage our providers to also bill their taxonomy code in box 24Ja to avoid possible delays in processing. Claims missing the requirements will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered “clean” and therefore cannot be accepted into our system.

We recommend that providers notify Kentucky Spirit Health Plan 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider’s TIN and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service,
- The service provided is a covered benefit under the member's contract on the date of service, and
- Referral and prior authorization processes were followed, if applicable.

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual.

For additional information on Kentucky Spirit Health Plan billing guidelines, please refer to our Billing Manual.

**Timely Filing**

Providers must submit all original claims (first time claims) and encounters to Kentucky Spirit Health Plan within three hundred and sixty five (365) calendar days of the date of service. When Kentucky Spirit Health Plan is the secondary payer, claims must be received within ninety (90) calendar days of the final determination of the primary payer.

**Electronic Transactions (EDI)**

Kentucky Spirit Health Plan is committed to providing our participating providers with the best tools possible to support their administrative needs. Our electronic transactions capabilities will speed up the processing and payment of your claims.

Electronic Transactions (EDI) support for HIPAA transactions is provided for the health plan by Centene Corporation. Centene is currently receiving professional, institutional, and encounter transactions electronically, as well as generating an electronic remittance
advice/explanation of payment (ERA/EOP). To conduct other HIPAA transactions please contact our EDI department at (800) 225-2573, ext. 25525.

Network providers are encouraged to participate in Kentucky Spirit Health Plans’ electronic claims/encounter filing program. The plan has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, it has the ability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP).

For more information on electronic filing and what clearinghouses Kentucky Spirit Health Plan has partnered with, contact:

Kentucky Spirit Health Plan
  c/o Centene EDI Department
  1-800-225-2573, extension 25525
  or by e-mail at:
  EDIBA@centene.com

Providers that bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

**Paper Claims Submission**

All claims and encounters should be submitted to:

**INITIAL CLAIMS, CORRECTED CLAIMS, AND REQUEST FOR RECONSIDERATION:**

Kentucky Spirit Health Plan
ATTN: CLAIMS DEPARTMENT
P.O. BOX 4001
Farmington, MO 63640-4401

**DISPUTED CLAIMS:**

Kentucky Spirit Health Plan
ATTN: CLAIMS DEPARTMENT
P.O. BOX 3000
Farmington, MO 63640-3800

**Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)**

Kentucky Spirit Health Plan provides an innovative web-based solution for Electronic Funds Transfers (EFT’s) and Electronic Remittance Advices (ERA’s). Through this service, providers can take advantage of EFTs and ERAs to settle claims electronically. As a Provider, you can gain the following benefits from using EFT and ERA:
• Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying
• Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
• Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported
• Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily

For more information, please visit our provider home page on our website at www.kentuckyspirithealth.com. If further assistance is needed, please contact Provider Services 1-866-643-3153.

Claim Payment
Clean claims will be adjudicated (finalized as paid or denied) at the following levels:
  • 90% within 30 business days of the receipt
  • 99% within 90 business days of the receipt

Third Party Liability
Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member.

Kentucky Spirit Health Plan is always the payer of last resort. Kentucky Spirit Health Plan providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Kentucky Spirit Health Plan members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform Kentucky Spirit Health Plan that efforts have been unsuccessful. Kentucky Spirit Health Plan will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, Kentucky Spirit Health Plan will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

ENCOUNTERS

What is an Encounter Versus a Claim?
An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our members. For example; if you are the PCP for a Kentucky Spirit Health Plan member and receive a monthly capitation amount for services, you must file an encounter (also referred to as an “proxy claim”) on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or “proxy claim” is paid at zero dollar amounts. It is mandatory that your office submits encounter data. Kentucky Spirit Health Plan utilizes the
encounter reporting to evaluate all aspects of quality and utilization management, and it is required by HFS and by the Centers for Medicare and Medicaid Services (CMS). Encounters do not generate an EOP.

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP.

You are required to submit either an encounter or a claim for each service that you render to a Kentucky Spirit Health Plan member.

**Procedures for Filing a Claim/Encounter Data**
Kentucky Spirit Health Plan encourages all providers to file claims/encounters electronically. See the Electronic Claims Submission section and the Provider Billing Manual for more information on how to initiate electronic claims/encounters.

**Billing the Member**
Kentucky Spirit Health Plan reimburses only services that are medically necessary and covered through the Kentucky Spirit Health Plan program. Providers are not allowed to “balance bill” for covered services if the provider’s usually and customary charge for covered services is greater than our fee schedule.

Providers may bill members for services NOT covered by either Medicaid or Kentucky Spirit Health Plan or for applicable co-payments, deductibles or coinsurance as defined by the State of Kentucky.

In order for a provider to bill a member for services not covered under the Kentucky Spirit Health Plan program, or if the service limitations have been exceeded, the provider must obtain a written acknowledgement following this language:

*I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Kentucky’s Coordinated Care Network program as being reasonable and medically necessary for my care. I understand that Kentucky Spirit Health Plan through its contract with the Kentucky Department of Health and Hospitals determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.*

For more detailed information on Kentucky Spirit Health Plan billing requirements, please refer to the Billing Manual available on the website [www.KentuckySpiritHealth.com](http://www.KentuckySpiritHealth.com).
CREDENTIALING and RECREREDENTIALING

The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by the Kentucky Spirit Health Plan, as well as government regulations and standards of accrediting bodies. All providers who participate with Kentucky Spirit Health Plan must have a Kentucky Medicaid provider number.

*Note: In order to maintain a current provider profile, providers are required to notify Kentucky Spirit Health Plan of any relevant changes to their credentialing information in a timely manner.*

Physicians must submit at a minimum the following information when applying for participation with Kentucky Spirit Health Plan:

- Complete signed and dated Kentucky Standardized Credentialing application KAPER-1, MAP-811 form (if the provider does not have a valid Kentucky Medicaid number), or grant Kentucky Spirit Health Plan access to the Council for Affordable Quality Health Care (CAQH) application,
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation,
- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider’s name, or evidence of compliance with Kentucky regulations regarding malpractice coverage or alternate coverage,
- Copy of current Drug Enforcement Administration (DEA) registration Certificate,
- Copy of W-9,
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable,
- Copy of current unrestricted medical license to practice in the state of Kentucky, if practicing in Kentucky.
- Current copy of specialty/board certification certificate, if applicable,
- Curriculum vitae listing, at a minimum, a five year work history (not required if work history is completed on the application),
- Signed and dated release of information form not older than one hundred and twenty (120) days,
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training,
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Providers must have a valid Kentucky Medicaid ID number to be considered eligible to participate in the Kentucky Spirit Health Plan provider network. Kentucky Spirit Health Plan will assist providers who do not have a Kentucky Medicaid number obtain one. A provider who does not have a valid Kentucky Medicaid number must submit a completed MAP-811 form to Kentucky Spirit Health Plan (do not submit to the State directly) in addition to the KAPER-1 credentialing application form and any additional documents required to complete the Kentucky Medicaid enrollment process. The MAP-811 form may be obtained from a Kentucky Spirit provider relations specialist or contracting representative.
Kentucky Spirit Health Plan will verify the following information submitted for Credentialing and/or Re-credentialing:

- Kentucky license through appropriate licensing agency,
- Board certification, or residency training, or medical education,
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions,
- Hospital privileges in good standing or alternate admitting arrangements,
- Review five year work history,
- Review federal and State sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General and State Medicaid Agencies).

Once the application is completed, the Kentucky Spirit Health Plan’s Credentialing Committee (“Credentialing Committee”) will render a final decision on acceptance following its next regularly scheduled meeting.

Providers must be credentialed prior to accepting or treating members. PCPs cannot accept member assignments until they are fully credentialed.

**Credentialing Committee**

The Credentialing Committee has the responsibility to establish and adopt as necessary, criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination.

Committee meetings are held at least quarterly and more often as deemed necessary.

*Note: Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.*

Site visits are performed at practitioner offices within 60 days of identification of two or more member complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the practitioner’s site visit score is less than eighty percent (80%), the practitioner may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices and safety procedures.

**Re-Credentialing**

To comply with accreditation standards, Kentucky Spirit Health Plan conducts the re-credentialing process for providers at least every thirty six months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner’s licensure, sanctions, certification, competence, or health status which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners, primary care providers, specialists, and ancillary providers/facilities previously credentialed to practice within the Kentucky Spirit Health Plan network.

In between credentialing cycles, Kentucky Spirit Health Plan conducts ongoing sanction monitoring activities on all network providers. This includes an inquiry to the appropriate
Kentucky State Licensing Agency for a review of newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry insures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, Kentucky Spirit Health Plan reviews monthly reports released by the Office of Inspector General and local Medicaid Agencies to review for any network providers who have been newly sanctioned or excluded from participation in Medicare/Medicaid.

A provider's agreement may be terminated if at any time it is determined by the Kentucky Spirit Health Plan Credentialing Committee that credentialing requirements are no longer being met.

**Right to Review and Correct Information**

All providers participating within the Kentucky Spirit Health Plan network have the right to review information obtained by Kentucky Spirit Health Plan to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the Kentucky Spirit Health Plan credentialing department. Upon receipt of this information, the provider will have 14 days to provide a written explanation detailing the error or the difference in information to the credentialing department. The Kentucky Spirit Health Plan Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

**Right to Be Informed of Application Status**

All providers who have submitted an application to join Kentucky Spirit Health Plan have the right to be informed of the status of their application upon request. To obtain status, contact the Kentucky Spirit Health Plan Provider Relations department at 1-866-643-3153.

**Right to Appeal Adverse Credentialing Determinations**

Existing provider applicants who are declined for continued participation for reasons such as quality of care or liability claims issues have the right to request a reconsideration of the decision in writing within 14 days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant’s reconsideration for participation in the Kentucky Spirit Health Plan network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 60 days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two weeks of the final decision.
Kentucky Spirit Health Plan members have the following **rights:**

- To receive information about Kentucky Spirit Health Plan, its benefits, its services, its network providers, and member rights and responsibilities.
- To be treated with respect and with due consideration for your dignity and the right to privacy and non-discrimination as required by law.
- To access all covered services, including certified nurse midwife services and pediatric or family nurse practitioner services.
- To participate with your doctors in making decisions regarding your healthcare, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To receive healthcare services that are accessible, are comparable in amount, duration, and scope to those provided under Medicaid Fee-For-Service (FFS) and are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive assistance from both Medicaid and Kentucky Spirit Health Plan in understanding the requirements and benefits of Kentucky Spirit Health Plan.
- To receive family planning services from any participating Medicaid doctor without prior authorization.
- To a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To receive information on the Grievance, Appeal and Medicaid’s State Fair Hearing procedures.
- To voice grievances or file appeals about Kentucky Spirit Health Plan decisions that affect your privacy, benefits, or the care provided.
- To request and receive a copy of your medical record.
- To make recommendations regarding Kentucky Spirit Health Plan’s member rights and responsibilities policies.
- To request that your medical record be corrected.
- To expect your medical records and care be kept confidential as required by law.
- To receive Kentucky Spirit Health Plan’s policy on referrals for specialty care and other benefits not provided by the member’s PCP.
- To privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information).
- To exercise these rights without adversely affecting the way Kentucky Spirit Health Plan and its network providers treat you.
- To allow or refuse your personal information be sent to another party for other uses unless the release of information is required by law.
- To choose a PCP and to change to another PCP in Kentucky Spirit Health Plan’s network.
- To receive timely access to care, including referrals to specialists when medically necessary without barriers.
- To file for a Medicaid State Fair Hearing.
• To receive materials – including enrollment notices, information materials, instructional materials, and available treatment options and alternatives - in a manner and format that may be easily understood.
• To make an advance directive, such as a living will.
• To choose a person to represent you for the use of your information by Kentucky Spirit Health Plan if you are unable to.
• To get a second opinion from a qualified healthcare professional.
• To receive oral interpretation services free of charge for all non-English languages.
• To be notified that oral interpretation is available and how to access those services.
• As a potential member, to receive information about the basic features of managed care; which populations may or may not enroll in the program and Kentucky Spirit Health Plan’s responsibilities for coordination of care in a timely manner in order to make an informed choice.
• To receive information on the following:
  o Benefits covered.
  o Procedures for obtaining benefits, including any authorization requirements.
  o Cost sharing requirements.
  o Service area.
  o Names, locations, telephone numbers and non-English language spoken by current Kentucky Spirit Health Plan doctors, including at a minimum, PCPs, specialists, and hospitals.
  o Any restrictions on your freedom of choice among network providers.
  o Doctors who are not accepting new patients.
  o Benefits not offered by Kentucky Spirit Health Plan, but available to you and how to obtain those benefits, including how transportation is provided.
• To receive a complete description of disenrollment rights at least annually.
• To receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change.
• To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
  o What constitutes an emergency medical condition, emergency services, and post-stabilization services.
  o Those emergency services do not require prior authorization.
  o The process and procedures for obtaining emergency services.
  o The locations of any emergency settings and other locations at which doctors and hospitals furnish emergency services and post-stabilization services covered under the contract.
  o Your right to use any hospital or other setting for emergency care.
  o Post-stabilization care services rules in accordance with Federal guidelines.

Kentucky Spirit Health Plan members have the following responsibilities:

• To inform Kentucky Spirit Health Plan of the loss or theft of their ID card.
• To present your ID card when using healthcare services.
• To be familiar with Kentucky Spirit Health Plan procedures to the best of your ability.
• To call or contact Kentucky Spirit Health Plan to obtain information and have questions clarified.
To provide information (to the extent possible) that Kentucky Spirit Health Plan and its doctors need in order to provide care.

To follow the prescribed treatment (plans and instructions) for care that has been agreed upon with your doctors.

To inform your doctor on reasons you cannot follow the prescribed treatment of care recommended by your doctor.

To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

To keep your medical appointments and follow-up appointments.

To access preventive care services.

To follow the policies and procedures of Kentucky Spirit Health Plan and Medicaid.

To be honest with doctors and treat them with respect and kindness.

To get regular medical care from your PCP before seeing a specialist.

To follow the steps of the appeal process.

To notify Kentucky Spirit Health Plan, Medicaid, and your doctors of any changes that may affect your membership, your healthcare needs, or your access to benefits. Some examples may include:

- If you have a baby.
- If your address changes.
- If your telephone number changes.
- If you or one of your children are covered by another plan.
- If you have a special medical concern.
- If your family size changes.

To keep all your scheduled appointments

To be on time for your scheduled appointments

Ensure the member’s privacy, medical records are kept in a secure location

To cancel your scheduled appointments at least twenty-four (24) hours in advance if you cannot keep an appointment.

To access care by following Kentucky Spirit Health Plan rules; failure to do so may cause you may be responsible for the charges.

To report suspected fraud and abuse to Kentucky Spirit Health Plan

Provider Rights

Kentucky Spirit Health Plan providers have the right to:

- Be treated by their patients and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for members’ care
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor’s office, hospital, or other offices running smoothly
- Expect other network providers to act as partners in members’ treatment plans
- Expect members to follow their directions, such as taking the right amount of medication at the right times
- Make a complaint or file an appeal against Kentucky Spirit Health Plan and/or a member
- File a grievance with Kentucky Spirit Health Plan on behalf of a member, with the member’s consent
• Have access to information about Kentucky Spirit Health Plan quality improvement programs, including program goals, processes, and outcomes that relate to member care and services
• Contact Kentucky Spirit Health Plan Provider Services with any questions, comments, or problems,
• Collaborate with other healthcare professionals who are involved in the care of members

Provider Responsibilities

Kentucky Spirit Health Plan providers have the responsibility to:

• Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
  ➢ Recommend new or experimental treatments
  ➢ Provide information regarding the nature of treatment options
  ➢ Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may self administered
  ➢ Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment
• Treat members with fairness, dignity, and respect
• Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
• Maintain the confidentiality of members’ personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
• Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider’s practice/office/facility
• Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
• Allow members to request restriction on the use and disclosure of their personal health information
• Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records
• Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process
• Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
• Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
• Respect members’ advance directives and include these documents in the members’ medical record
• Allow members to appoint a parent, guardian, family member, or other representative if they can’t fully participate in their treatment decisions
- Allow members to obtain a second opinion, and answer members’ questions about how to access healthcare services appropriately
- Follow all state and federal laws and regulations related to patient care and patient rights
- Participate in Kentucky Spirit Health Plan data collection initiatives, such as HEDIS and other contractual or regulatory programs
- Review clinical practice guidelines distributed by Kentucky Spirit Health Plan
- Comply with Kentucky Spirit Health Plan Medical Management program as outlined in this manual.
- Disclose overpayments or improper payments to Kentucky Spirit Health Plan
- Provide members, upon request, with information regarding the provider’s professional qualifications, such as specialty, education, residency, and board certification status
- Obtain and report to Kentucky Spirit Health Plan information regarding other insurance coverage
- Notify Kentucky Spirit Health Plan in writing if the provider is leaving or closing a practice
- Contact Kentucky Spirit Health Plan to verify member eligibility or coverage for services, if appropriate
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible
- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language
- Not be excluded, penalized, or terminated from participating with Kentucky Spirit Health Plan for having developed or accumulated a substantial number of patients in the Kentucky Spirit Health Plan with high cost medical conditions
- Object to providing relevant or medically necessary services on the basis of the provider’s moral or religious beliefs or other similar grounds
- Disclose to Kentucky Spirit Health Plan, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial financial risk between Kentucky Spirit Health Plan and the physician or physician group
- Notify Kentucky Spirit Health Plan of any demographic changes

**GRIEVANCES AND APPEALS PROCESS**

**Member Grievances and Provider Complaints**

A member grievance is defined as any member expression of dissatisfaction about any matter other than an “adverse action”. A provider complaint is any provider expression of dissatisfaction about any matter other than a claims dispute. **Note:** Throughout this Manual, we will consider the term “grievance” to refer to both member grievances and provider complaints as the resolution processes are the same. Provider complaints include disputes regarding policies, procedures or any aspect of Kentucky Spirit Health Plans’ administrative functions including proposed actions.
The grievance process allows the member, or the member’s authorized representative (provider, family member, etc.) acting on behalf of the member, to file a grievance either orally or in writing within 30 calendar days of the event covering the dissatisfaction. Kentucky Spirit Health Plan shall acknowledge receipt of each grievance in writing within 5 working days of receipt of the grievance. A provider MAY NOT file a grievance or appeal on behalf of a member without written designation by the member or the member's representative. Any individuals who makes a decision on grievances will not be involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, Kentucky Spirit Health Plan shall ensure that the decision makers are health care professionals with the appropriate clinical expertise in treating the member’s condition or disease. Kentucky Spirit Health Plan values its providers and will not take punitive action against providers who file a grievance on a member’s behalf.

Acknowledgement
Staff receiving grievances orally will acknowledge the grievance and attempt to resolve them immediately. Staff will document the substance of the grievance. For informal grievances, defined as those received orally and resolved immediately to the satisfaction of the member, representative or provider, the staff will document the resolution details. Member notification of the grievance resolution shall be made in writing within two business days of the resolution. The Grievance and Appeals Coordinator (GAC) will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within five business days of receipt.

Grievance Resolution Time Frame
Grievance Resolution will occur as expeditiously as the member’s health condition requires, not to exceed 30 calendar days from the date of the initial receipt of the grievance. Grievances will be resolved by the GAC, in coordination with other Kentucky Spirit Health Plan staff as needed. In our experience, most grievances are resolved at the staff level to the satisfaction of the member, representative or provider filing the grievance. Expedited grievance reviews will be available for members in situations deemed urgent, such as a denial of an expedited appeal request, and will be resolved within 24 hours.

Kentucky Spirit Health Plan may extend the resolution of a grievance by up to 14 calendar days if the member or a member representative requests the extension or if Kentucky Spirit Health Plan determines that there is a need for additional information and the extension is in the member’s interest. For any extension not requested by the member, Kentucky Spirit Health Plan will give the member written notice of the reason for the extension within two working days of the decision to extend the timeframe.

Notice of Resolution
The GAC will provide written resolution to the member, representative or provider within 30 calendar days of receipt. The letter will include but not limited to: all information considered in investigating the grievance; findings and conclusions; the deposition of the grievance; the right to a second level review by the Grievance Appeal Committee (GAC) if the member is not satisfied.
The grievance response shall include, but not be limited to, the decision reached by Kentucky Spirit Health Plan, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the enrollee. A copy of verbal complaints logs and records of disposition or written grievances shall be retained for five years.

Grievances may be submitted by written notification to:

Kentucky Spirit Health Plan
Grievances and Appeals Coordinator (GAC)
201 East Main Street
Lexington, Kentucky 40507
1-866-643-3153

Appeals
An appeal is the request for review of a “Notice of Adverse Action”. A “Notice of Adverse Action” 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 part of payment for a service excluding technical reasons; the failure to render a decision within the required timeframes; or the denial of a member’s request to exercise his/her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the Kentucky Spirit Health Plan network. The review may be requested in writing or orally within thirty (30) calendar days of receiving the Notice of Adverse Action; however, oral requests for appeals within the standard timeframe must be resolved within 30 days of receipt of the appeal, with a 14 day extension possible if additional information is required. The legal guardian of the Member for minor or incapacitated adult, a representative of the minor designated in writing, or a provider acting on behalf of the Member with the Member’s written consent, have the right to file an appeal of an action on behalf of the Member. Kentucky Spirit Health Plan shall provide written notice that the appeal has been received within five business days of its receipt with the expected date of resolution. Members may request that Kentucky Spirit Health Plan review the Notice of Adverse Action to verify if the right decision has been made.

If a member is receiving authorized services that are now denied and wishes to keep getting these services, an appeal must be submitted in writing within 10 calendar days of the denial letter. The request must clearly state that the member wish to keep getting the denied services. Member can keep getting these services until the appeal decision is rendered. If appeal decision upholds Kentucky Spirit’s denial, the member may have to pay for the services.

Expeditied Appeals
Expeditied appeals may be filed when either Kentucky Spirit Health Plan or the member’s provider determines that the time expended in a standard resolution could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expeditied resolution or supports a member’s appeal. In instances where the member’s request for an expeditied appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.
Decisions for expedited appeals are issued as expeditiously as the member’s health condition requires, not exceeding three working days from the initial receipt of the appeal. Kentucky Spirit Health Plan may extend this timeframe by up to an additional 14 calendar days if the member requests the extension or if Kentucky Spirit Health Plan provides evidence satisfactory to the States that a delay in rendering the decision is in the member’s interest. For any extension not requested by the member, Kentucky Spirit Health Plan shall provide written notice to the member of the reason for the delay. Kentucky Spirit Health Plan shall make reasonable efforts to provide the member with prompt verbal notice of any decisions that are not resolved wholly in favor of the member and shall follow-up within two (calendar days with a written notice of action.

Written notice shall include the following information:
(a) The decision reached by Kentucky Spirit Health Plan;
(b) The date of decision;
(c) For appeals not resolved wholly in favor of the member the right to request a State fair hearing and information as to how to do so; and
(d) The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the Kentucky Spirit Health Plan decision.

Call or mail all appeals to:
Kentucky Spirit Health Plan  
Grievances and Appeals Coordinator (GAC)
201 East Main Street  
Lexington, Kentucky 40507  
1-866-643-3153

State Fair Hearing Process
Kentucky Spirit Health Plan will include information in the Member Handbook, online and via the appeals process to members of their right to appeal directly to the State. The member has the right to appeal to the State at the same time that they appeal to Kentucky Spirit Health Plan, after exhausting appeal rights with Kentucky Spirit Health Plan, or instead of appealing to Kentucky Spirit Health Plan.

Any adverse action or appeal that is not resolved wholly in favor of the member by Kentucky Spirit Health Plan may be appealed by the member or the member’s authorized representative to the State for a fair hearing. Kentucky Spirit Health Plans’ denial of payment for Kentucky Medicaid covered services and failure to act on a request for services within required timeframes may also be appealed. Appeals must be requested in writing by the member or the member’s representative within 30 days of the member’s receipt of notice of adverse action.

For member appeals, Kentucky Spirit Health Plan is responsible for providing to the State (and to the member, upon request) an appeal summary describing the basis for the denial. For standard appeals, the appeal summary must be submitted to the State five (5) calendar days from the date of notification that a State Fair Hearing has been filed. These records may be made available to the member upon request by either the member or the member’s
legal counsel. The State will provide the member with a hearing process that adheres to the criteria set forth in 907 KAR 1:563, 42 CFR 438 Subpart F and 42 CFR 431 Subpart E.

Kentucky Spirit Health Plan shall comply with the State’s fair hearing decision. The State’s decision in these matters shall be final and shall not be subject to appeal by Kentucky Spirit Health Plan.

**Reversed Appeal Resolution**

If Kentucky Spirit Health Plan or the state fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, Kentucky Spirit Health Plan will authorize the disputed services promptly and as expeditiously as the member’s health condition requires. Additionally, in the event that services were continued while the appeal was pending, Kentucky Spirit Health Plan will provide reimbursement for those services in accordance with the terms of the final decision rendered by the States and applicable regulations.

To File A Medicaid State Hearing in writing, by fax, or in person:

**Kentucky Department for Medicaid Services**  
Division of Administrative and Financial Management  
275 East Main St., 6W-C  
Frankfort, KY 40621  
Fax number: (502) 564-6917

**FRAUD AND ABUSE**

**Authority and Responsibility**

The Kentucky Spirit Health Plan Director of Regulatory Affairs & Compliance has overall responsibility and authority for carrying out the provisions of the compliance program. Kentucky Spirit Health Plan is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The Kentucky Spirit Health Plan provider network will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

**Lock-In Program**

Kentucky Spirit Health Plan administers a Lock-In Program to address member over-utilization of services, including pharmacy and non-emergent use of the emergency room. The purpose of this program is to decrease the over-utilization of these services, thus improving the member’s quality of care and quality of life.

At the time of member enrollment into the Lock-In program, Kentucky Spirit Health Plan will provide written notification to the member along with the designated lock-in providers and the member’s right to appeal the Plan’s decision. The member is initially locked-in for a twenty-four (24) month period, during which PCP changes are not allowed, unless as specified in subsection (1) of Section 6 in 907 KAR 1:677. Following this twenty-four month
period, utilization review for this member is conducted at twelve (12) month intervals to determine the member’s continued need for the program.

**Medical/Pharmacy Lock-In:**
If the following occurs within two (2) consecutive 180 calendar day periods, the member is locked into one (1) primary care provider, one (1) controlled substance prescriber, and one (1) pharmacy:

- Member received services from at least five (5) different providers;
- Member received at least ten (10) different prescription drugs; and
- Member received prescriptions from at least three (3) or more different pharmacies.

Kentucky Spirit Health Plan will select a *primary care provider* for the member who:

- Is accessible within normal time and distance standards for the community in which the recipient resides;
- Has admitting privileges to the designated hospital, if the lock-in recipient has a designated hospital

Primary care Providers participating in the Lock In Program agree to:

- Provide services and manage the lock-in recipient’s necessary health care services
- Complete and forward a Lock-in Recipient Referral to a referred provider, if the lock-in recipient needs a Medicaid-covered service other than the service of the designated primary care provider
- Participate in the recipient’s periodic utilization review to determine continued lock-in status
- Serve as the lock-in recipient’s designated controlled substance prescriber, if the designated primary care provider is a physician

**Hospital Lock-In:**
If the following occurs within two (2) consecutive 180 calendar day periods, the member is locked into a designated hospital for *nonemergency* care (except for a screening to determine if an emergency medical condition exists), and into one (1) primary care provider, one (1) controlled substance prescriber, and one (1) pharmacy.

- Had at least four (4) hospital emergency department visits for a condition that was not an emergency medical condition; or
- Received services from at least three (3) different hospital emergency departments for a condition that was not an emergency medical condition.

*For emergency medical conditions, the member will not be restricted to receiving services from a particular provider.*

**Referral to Lock-In Program:**
Kentucky Spirit Health Plan will monitor member claims history and utilization to identify members who may benefit from enrollment in the lock-in program. Members may also be referred for evaluation for participation in the Lock-In Program by their Primary Care
Physician or a Specialist who is caring for the member. Excluded from enrollment in the lock-in program are members who:

- Reside in a facility reimbursed pursuant to 907 KAR 1:025 or 1:065 or in a personal care home
- Are under the age of eighteen (18)
- Receive services through a home and community based waiver program or hospice services
- Utilized Medicaid services at a frequency or amount which was medically necessary to treat a complex, life threatening medical condition.

For further information or questions about the Lock-In Program please contact Medical Management at 1-866-643-3153.

**Waste Abuse and Fraud (WAF) System**

Kentucky Spirit Health Plan takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a waste, abuse and fraud (WAF) program that complies with Kentucky regulations and federal laws. Kentucky Spirit Health Plan, in conjunction with its management company, Centene Corporation, successfully operates a waste, abuse and fraud unit. Kentucky Spirit Health Plan performs front and back end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. The Special Investigation Unit (SIU) performs back end audits which in some cases may result in taking the appropriate actions against those who, individually or as a practice, commit waste, abuse, and/or fraud, including but not limited to:

- Remedial education and/or training around eliminating the egregious action
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify

Some of the most common WAF submissions seen are:

- Unbundling of codes
- Up-coding
- Add-on codes without primary CPT
- Diagnosis and/or procedure code not consistent with the member’s age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of Benefits
- Claims for services not rendered

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential helpline at 1-866-685-8664. Kentucky Spirit Health Plan and/or Centene take all reports of potential waste, abuse or fraud very seriously and investigate all reported issues.
Kentucky Spirit Health Plan culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs. This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions.

Kentucky Spirit Health Plan recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, Kentucky Spirit Health Plan will provide for the delivery of quality care with the primary goal of improving the health status of its members. Where the member's condition is not amenable to improvement, Kentucky Spirit Health Plan will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the Kentucky Spirit Health Plan QAPI program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

**Program Structure**

Kentucky Spirit Health Plan Board of Directors (BOD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BOD oversees the QAPI program and has established various committees and ad-hoc committees to monitor and support the QI program.

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the QI, UM, and Credentialing programs.

The following sub-committees report directly to the Quality Improvement Committee:

- Credentialing Committee
- Utilization Management Committee
- Pharmacy and Therapy Committee
- Performance Improvement Team
- Member and Provider Advisory Committee
- Peer Review Committee (Ad Hoc Committee)
- Community Advisory Committee
**Practitioner Involvement**

Kentucky Spirit Health Plan recognizes the integral role practitioner involvement plays in the success of its QAPI program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Kentucky Spirit Health Plan encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as but not limited to, the QIC, Credentialing Committee, Pharmacy & Therapeutics (P&T) and select ad-hoc committees.

**Quality Improvement Program Scope and Goals**

The scope of the QAPI program is comprehensive and addresses both the quality of clinical care and the quality of service provided to the Kentucky Spirit Health Plans’ members. Kentucky Spirit Health Plan’s QAPI program incorporates all demographic groups, care settings, and services in QI activities, including preventive care, primary care, specialty care, acute care, short-term care, long-term care (depending upon the product), and ancillary services, and operations.

Kentucky Spirit Health Plans’ primary QAPI goal is to improve members’ health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

To that end, the Kentucky Spirit Health Plan QAPI program monitors the following:

- Compliance with preventive health guidelines and practice guidelines
- Acute and chronic care management
- Provider network adequacy and capacity
- Selection and retention of providers (credentialing and recredentialing)
- Behavioral healthcare within benefits
- Delegated entity oversight
- Continuity and coordination of care
- Utilization Management, including under and over utilization
- Compliance with member confidentiality laws and regulation
- Employee and provider cultural competency
- Provider appointment availability
- Provider and Health Plan after-hours telephone accessibility
- Member satisfaction
- Provider satisfaction
- Member grievance system
- Provider complaint system
- Member enrollment and disenrollment
- PCP changes
- Department performance and service
- Patient safety
- Marketing practices
**Patient Safety and Quality of Care**

Patient Safety is a key focus of Kentucky Spirit Health Plans’ QAPI program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual quality of care events. A potential quality of care (QOC) issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member. Kentucky Spirit Health Plan employees (including medical management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential quality of care issues. Adverse events may also be identified through claims based reporting. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

**Performance Improvement Process**

Kentucky Spirit Health Plans’ QIC reviews and adopts an annual QAPI program and QI work plan based on managed care Medicaid appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or the service.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Kentucky Spirit Health Plan to monitor improvement over time.

Annually, Kentucky Spirit Health Plan develops a QAPI Work Plan for the upcoming year. The QAPI work plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QI activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI work plan.

Kentucky Spirit Health Plan communicates activities and outcomes of its QAPI program to both members and providers through avenues such as the member newsletter, provider newsletter and the Kentucky Spirit Health Plan web portal at [www.KentuckySpiritHealth.com](http://www.KentuckySpiritHealth.com).

At any time, Kentucky Spirit Health Plan providers may request additional information on the health plan programs including a description of the QAPI program and a report on the
progress in meeting the QAPI program goals by contacting the Quality Improvement department.

**Health Employer Data Information Set (HEDIS)**

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the Kentucky State Medicaid contract.

As both the Kentucky and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. Kentucky purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company’s ability to demonstrate an improvement in preventive health outreach to its members. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs such as ‘pay for performance’ and ‘quality bonus funds’.

**How are HEDIS rates calculated?**

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim or encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual chlamydia screening, annual pap test, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews (see Kentucky Spirit Health Plans’ website and HEDIS brochure for more information on reducing HEDIS medical record reviews). Measures typically requiring medical record review include: childhood immunizations, well child visits, diabetic HbA1c, LDL, eye exam and nephropathy, controlling high-blood pressure, and prenatal care and postpartum care.

**Who will be conducting the Medical Record Reviews (MRR) for HEDIS?**

Kentucky Spirit Health Plan will contract with a national medical record review vendor, to conduct the HEDIS medical record reviews on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, you may receive a call from a medical record reviewer representative if any of your patients are selected into the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient.
medical record review vendor will sign a HIPAA compliant Business Associate Agreement with Kentucky Spirit Health Plan which allows them to collect PHI on our behalf.

What can be done to improve my HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided.
- Bill CPT II codes related to HEDIS measures such as diabetes, eye exam and blood pressure.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at 1-866-643-3153.

Provider Satisfaction Survey

Kentucky Spirit Health Plan conducts an annual provider satisfaction survey which includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management, and provider services. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by Kentucky Spirit Health Plan, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives.

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well we are meeting the members’ expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

Provider Profiling

Over the past several years provider profiling has emerged as a promising strategy to improve the quality and cost-effectiveness of care. Kentucky Spirit Health Plan currently uses physician profiling to improve care and services provided to Kentucky Spirit Health Plan members.

The provider profiling program promotes efforts that are consistent with the Institute of Medicine’s aims for advancing quality (safe, beneficial, timely, patient-centered, efficient and equitable) as well as recommendations from other national agencies such as the CMS-AMA Physician Consortium, NCQA and NQF. Kentucky Spirit Health Plan encourages accurate
and timely submission of preventive health and disease monitoring services in accordance with evidence-based clinical practice guidelines.

The goals of Kentucky Spirit Health Plans’ Provider Profiling program are:

- Increase provider awareness of his/her performance in key areas
- Motivate providers to establish measurable performance improvement processes relevant to Kentucky Spirit Health Plans’ member populations in their practices
- Use peer performance data and/or other established benchmarks to identify outlier provider practices that reflect best practices or less than optimal performance
- Increase opportunities for Kentucky Spirit Health Plan to partner with providers to achieve measurable improvement in health outcomes by developing, implementing, and monitoring practice-based performance improvement initiatives

Kentucky Spirit Health Plan will accomplish these goals by:

- Producing and distributing provider-specific reports containing meaningful, reliable, and valid data for evaluation by Kentucky Spirit Health Plan and the provider.
- Establishing and maintaining an open dialogue with profiled providers related to performance improvement.

Physicians, meeting a minimum panel threshold, will receive a quarterly profile report with an individual score for each measure. Scores will be benchmarked per individual measure and compositely to the Kentucky Spirit Health Plan network average and as applicable, to the then available NCQA Medicaid mean. Provider profile indicator data is not risk adjusted and scoring is based on provider performance within the service area range.

PCPs who meet or exceed established performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by Kentucky Spirit Health Plan in publications such as newsletters, bulletins, press releases, and recognition in our provider directories as well as being eligible for applicable financial incentive programs. More information on our provider profiling programs can be found on the provider web portal or by contacting Kentucky Spirit Health Plans’ Contracting and/or Provider Relations departments.

**MEDICAL RECORDS REVIEW**

**Medical Records**

Kentucky Spirit Health Plans’ providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Kentucky Spirit Health Plan to review the quality and appropriateness of the services rendered. To ensure the member’s privacy, medical records should be kept in a secure location. Kentucky Spirit Health Plan requires providers to maintain all records for members for at least seven years. See the Member Rights section of this manual for policies on member access to medical records.
Required Information

Medical records means the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member’s participating primary care physician or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member’s name, and/or medical record number on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed, or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Kentucky Spirit Health Plan’s practice guidelines.
- Appropriate subjective and objective information pertinent to the member’s presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed and drug administered or dispensed including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Signed and dated required consent forms.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases.
• Health teaching and/or counseling is documented.
• For members 10 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried).
• Documentation of failure to keep an appointment.
• Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
• Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
• Confidentiality of member information and records protected.
• Evidence that an advance directive has been offered to adults 18 years of age and older.

**Medical Records Release**

All member medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person’s legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

**Medical Records Transfer for New Members**

All PCPs are required to document in the member’s medical record attempts to obtain historical medical records for all newly assigned Kentucky Spirit Health Plan member. If the member or member’s guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers then this should also be noted in the medical record.

**Medical Records Audits**

Kentucky Spirit Health Plan will conduct random medical record audits as part of its Quality Improvement Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit. Kentucky Spirit Health Plan will provide written notice prior to conducting a medical record review.

For questions or concerns regarding the provider manual please contact Provider Relations at 1-866-643-3153.
