



CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES

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**Mark D. Birdwhistell**  
Secretary

**Glenn Jennings**  
Commissioner

August 10, 2006

**Re: *KyHealth Choices* – Prior Authorization Requirements**

Provider Letter: A-70

Dear *KyHealth Choices* Provider:

On August 1, 2006 the Department for Medicaid Services (DMS) implemented Prior Authorization (PA) requirements for *KyHealth Choices*. With the implementation, providers have had difficulties contacting SHPS or have experienced lengthy hold times in obtaining Prior Authorizations for services. In response to this problem, 52 phone lines and 25 additional staff persons have been made available to assist with PA requests.

Additionally, in an effort to allow providers adequate time to transition to the new PA requirements, DMS is initiating the following changes immediately:

- PA requirements of radiology procedures and therapy services (physical, chiropractic, occupational and speech) as identified in Provider Letter A-69 will not be required until September 15, 2006. Providers should continue to obtain PA for the required services and will not be excused from that responsibility during this transition period.

To ensure continuity of services, claims with dates of service from August 1, 2006 through September 14, 2006 will not be denied for failure to meet the new *KyHealth Choices* PA requirements. Any services obtained during this time period will be counted against member's service limits.

- PA requests may be obtained from either the rendering provider or the ordering provider, as long as the caller can supply all required information to complete the request. Provider Letter A-69 includes a frequently asked questions list. You may obtain Provider Letter A-69 from the Department of Medicaid Services website at [www.chfs.ky.gov/dms](http://www.chfs.ky.gov/dms); click on the "Provider Resources" link on the left side the page, then click on the "KyHealth Choices - Prior Authorization Information" link.



*KyHealth Choices Provider*

August 10, 2006

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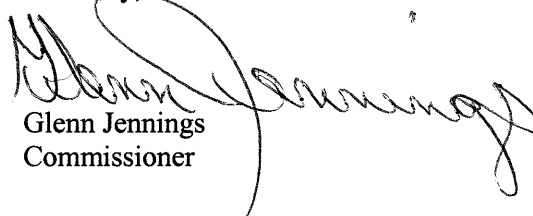
- Effective August 7, 2006, a temporary option was made available for providers to obtain the PA number. An initial reference number is created when member demographic and clinical information is entered into the system by EDS/SHPS. If the authorization for service is approved, a PA number (to be used for billing purposes) is assigned within 24 hours. After 24 hours of receiving your initial reference number, you may call 1-800-807-1232, choose the option "PA," and call center personnel will provide you with the PA number. A letter will be received by the rendering provider to prove authorization within five to seven business days.
- LTC facilities (provider type 12) and ICF/MR facilities (provider type 11) are excluded from the new PA requirements and service limits. LTC and ICF/MR facilities already authorize ancillary services and therefore have no new changes. For dual eligibles, those services that Medicare has allowed will not require PA.
- Claims for which commercial insurance has authorized services (whether a PA was or was not required by the commercial insurer) also require a Medicaid PA if required pursuant to Provider Letter A-69.

It should be noted that DMS is reviewing the list of services which require PA. These services may be subject to change. In the near future, we will advise you in writing of all services by procedure code which will require PA.

Additionally, EDS is currently investigating system changes that will allow you to check the status of PA requests through the automated voice response system and KyHealth Net. As these modifications become available, we will notify you so that you may begin utilizing them as soon as possible.

Thank you for your patience as we implement this new system. Should you have any questions, please contact the EDS Call Center at 1-800-807-1232.

Sincerely,



Glenn Jennings  
Commissioner

Xc: DMS PA ltr. A-70

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