Out of Network Services
of
Managed Care Organizations (MCOs)
Effective Nov. 1, 2011

CoventryCares of Kentucky Health Plan	
Behavioral Health	**For CoventryCares Behavioral Health Practitioners:** CoventryCares (MHNet) will honor all authorizations for behavioral health services issued by the Commonwealth of Kentucky for Medicaid specified authorization time periods* through Nov. 30, 2011. For these services previously approved by Medicaid, our care coordination team will outreach to the provider and member, as soon as possible, to transition the member to an in-network provider for services on and after Dec. 31, 2011. If a previously requested service is not available within the CoventryCares network and Medical Necessity criteria are met, the authorization will continue and CoventryCares Care Coordinators will provide assistance to the member and outreach to the provider for any additional care coordination needs. Out of network providers will be reimbursed at 100% of the Medicaid fee schedule for Medically Necessary services provided Nov. 1, 2011 through Dec. 31, 2011. **To provide these out of network services, however, out of network providers must follow the same prior authorization guidelines as network providers, which means that if CoventryCares does not require PA for specified in network services, PA for these same services out of network will not be required during this period.** Beginning Jan. 1, 2012, out of network providers will be reimbursed at 90% of the Medicaid Fee schedule for Medically Necessary covered services and must obtain prior authorization for all out of network services provided to eligible CoventryCares members. A list of the services requiring PA is available at CoventryCaresKY.com. Out of network providers may request new services for CoventryCares members by contacting our PA department by telephone at **888-604-6106**. An out of network provider may bill for a service for a CoventryCares member using the provider's unique National Provider Identifier (NPI). *If a CoventryCares member requires an extension of inpatient care/treatment beyond the Medicaid specified authorization time period, the provider must request (from CoventryCares) an extension of authorization for the care/treatment. If the extension is not requested, the provider's claim for the services will be denied and the provider will have to follow the retrospective review process, which includes meeting Medical Necessity criteria, in order to be considered for payment of the services.
Physical Health	**For CoventryCares Physical Health Practitioners:** CoventryCares of Kentucky will honor all physical health authorizations issued by the Commonwealth for specified authorization time periods* for out of network providers through Nov. 30, 2011. For these services previously approved by Medicaid, our care coordination team will outreach to the provider and member to transition the member to an in-network provider for services, as soon as possible, for services on and after Dec. 31, 2011. If a previously requested service is not available within our network and Medical Necessity criteria are met, the authorization will continue and our Care Coordinators will provide assistance to the member and outreach to the provider for any additional care coordination needs. Out of network providers will be reimbursed at 100% of the Medicaid fee schedule for Medically

	Necessary services provided Nov. 1, 2011 through Dec. 31, 2011. **To provide these out of network services, however, out of network providers must follow the same prior authorization guidelines as network providers, which means that if CoventryCares does not require PA for specified in network services, PA for these same services out of network will not be required during this period.** Beginning Jan. 1, 2012, out of network providers will be reimbursed at 90% of the Medicaid Fee schedule for Medically Necessary covered services and must obtain prior authorization for all out of network services provided to eligible CoventryCares members. A list of the services requiring PA is available at CoventryCaresKY.com. PA may be requested by telephone at **888-725-4969, or by** fax at **855-454-5579**. An out of network provider may bill for a service provided to a CoventryCares member using the provider's unique NPI. *If a CoventryCares member requires an extension of inpatient care/treatment beyond the Medicaid specified authorization time period, the provider must contact CoventryCares to request the extension of authorization for care/treatment. If the extension is not requested, the provider's claim for the services will be denied and the provider will have to follow the retrospective review process, which includes meeting Medical Necessity criteria, in order to be considered for payment of the services.

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WellCare of Kentucky Health Plan	
Behavioral Health	**For WellCare of Kentucky Behavioral Health Practitioners** WellCare's 90 day transition of care (TOC) plan (specified below) includes behavioral health, and mirrors the physical health process. If a patient is currently being treated for inpatient psychiatric conditions, WellCare will not interrupt the continuity of care; however, WellCare will work with the member and provider to transition the member's care from an out of network provider to an in network provider, where possible. WellCare will honor all authorizations obtained by the state prior to Nov. 1, 2011, for the Medicaid specified authorization time periods**.* If the state has not already issued an authorization, WellCare will cover all outpatient services provided during the transition period (through January 31, 2012) for in network and out of network providers regardless of whether an authorization is/is not obtained.** WellCare and its vendors will pay out of network providers based on 100% of the current Medicaid fee schedule through Jan. 31, 2012. A provider may bill for out of network service(s) for a WellCare member using the provider's unique National Provider Identifier (NPI) and Kentucky Medicaid provider numbers. For prior authorization, a provider may contact the applicable number as referenced on the WellCare's Quick Reference Guide at http://kentucky.wellcare.com/provideer/resources. Following the transition of care period (Feb. 1, 2012 going forward), ALL services of out of network providers must be authorized by WellCare. *If a WellCare member requires inpatient care/treatment beyond the Medicaid specified authorization time period, the provider must request (from WellCare) an extension of authorization for this care/treatment. If the extension of authorization is not requested, the provider's claim for these services will be denied and the provider will have to follow the retrospective review process, which includes meeting Medical Necessity criteria, in order to be considered for payment of the services.
Physical Health	**For WellCare of Kentucky Physical Health Practitioners** WellCare and its vendors will pay out of network providers based on 100% of the current Medicaid fee schedule through January 31, 2012. Please see the following information regarding the 90 day TOC. **Medical** 1) Within the 90 day transition period, WellCare will honor any authorizations the state has already given for the Medicaid specified prior authorization time periods*, whether they are inpatient or out patient, non-participating or participating. **2) If the state has not already issued an authorization, WellCare will cover all outpatient services provided through Jan. 31, 2012, par or non-participating (in network and out of network), regardless of whether or not authorization is/is not obtained.** 3) For inpatient admissions occurring Nov.1, 2011, or after, the facilities will need to request an authorization from WellCare*. For prior authorization, a provider may contact the applicable

number as referenced on the WellCare's Quick Reference Guide at http://kentucky.wellcare.com/provider/resources.

A provider may bill for out of network service(s) for a WellCare member using the provider's unique National Provider Identifier (NPI) and Kentucky Medicaid provider numbers.

*If a WellCare member requires inpatient care/treatment beyond the Medicaid specified authorization time period, the provider must request (from WellCare) an extension of authorization for the care/treatment. If the extension of authorization is not requested, the provider's claim for these services will be denied and the provider will have to follow the retrospective review process, which includes meeting Medical Necessity criteria, in order to be considered for payment of the services.

Vision (Avesis)

1) Aventis will honor any Commonwealth prior authorizations prior to Nov. 1, 2011, for the Medicaid specified prior authorization time periods; however, Avesis does not have any prior authorization requirements for KY Medicaid.
2) Non Par providers will need to submit via paper to Avesis Attn: Vision Claims, PO Box 7777 Phoenix, AZ 85011.
3) If the provider is Non Par, the provider will need to submit the claim via paper and Avesis will process them accordingly. A vision provider should bill for a service for a WellCare member using the provider's unique NPI and Kentucky Medicaid provider numbers; however, an Aventis-specific provider ID number is not required.

Dental (DentaQuest)

1) Dental Providers who are OON will need to submit their claims to: DentaQuest of Kentucky, LLC, North Corporate Parkway, Mequon, WI 53092; or fax their claims to be processed to: 262-834-3589. If additional assistance is needed Provider Services can be reached at 888-291-3762.
2) During the 90 day TOC period, if a claim is submitted for a service that required PA, a copy of the previous PA with a Medicaid specified prior authorization period*, must be submitted with the claim. If a claim is submitted with a PA, it will pend so the provider can be entered in the system. The claim will then reenter the work flow for proper payment and adjudication. If the provider chooses to remain out of network, the provider claims will be paid for the continuation of care period. If it is a new PA request, providers should follow the above mentioned submission process and DentaQuest will issue the PA approval and send the requestor the appropriate information to render the service(s).
3) Once the claim is received by DentaQuest, it will pend so that DentaQuest can enter the provider into the system. If the provider chooses to remain out of network their claims will be paid for the continuation of care period but the provider will not receive a provider number.

Hearing Vendor (Max Specialty Benefits (MSB))

Members will be allowed to continue care with current treating providers outside of the network for the Medicaid specified prior authorization periods, for the 90 day transition period in accordance with the state approved TOC policy.

1) The brief overview of the process is as follows for Out of Network Claims:

- The claims address is:
  Max Specialty Benefits, 4205 West Atlantic Avenue, Suite 401, Delray Beach, FL 33445.

  If the provider chooses to bill electronically, the provider must first call us at 561-455-9002, ext. 220, and complete a Provider Electronic Enrollment Form.

	• Claim received from an out of network provider with an existing Medicaid Prior Authorization: o MSB will contact the provider and inform them the claim is eligible to be paid at 100% of Medicaid. If the provider agrees, fax back the MSB Payment Acceptance Form. o MSB will one-time process the claim at the agreed rate. Future claims will have this process repeated. Out of Network Provider - o Out of network provider contacts MSB during the transition period requesting to stay on board through Dec. 31, 2011. o MSB informs the provider the payment rate is 100% of Medicaid. If the provider agrees, MSB will fax a provider acceptance form showing the provider as par until Dec. 31, 2011. 2) Prior Authorizations • Providers may contact Max Specialty Benefits, 4205 West Atlantic Avenue, Suite 401, Delray Beach, FL 33445, call us at **561-455-9002, ext.220** • Request from an out of network provider with an existing Medicaid Prior Authorization: o MSB will approve at 100% of Medicaid's fee schedule. If the provider agrees, fax back the MSB payment acceptance form. o MSB will one-time process the claim at the agreed rate. Future claims will have this process repeated. 3) The provider's NPI and Kentucky Medicaid provider numbers should be used to bill for services; however, a MSB-specific provider ID number is not required.

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Kentucky Spirit Health Plan (KSHP)	
Behavioral Health	**<u>For KSHP Behavioral Health Practitioners</u>** KSHP (Cenpatico) will pay medically necessary authorized out of network covered behavioral health or substance abuse services at 100% of the Medicaid fee schedule through Dec. 31, 2011. For dates of service January , 2012, and after, out of network providers will be paid at 90% of the Medicaid fee schedule for Medically Necessary covered services and will be subject to Prior Authorization. Out of network providers must obtain prior authorization for services; however, if an eligible a member meets InterQual criteria, KSHP/Cenpatico will work with providers so that claims will be paid for Medically Necessary services during the transition of care period – the first 30 days beginning on November 1, 2011. KSHP/Cenpatico will use that opportunity to encourage the out of network provider to become a participating provider. Beginning January 1, 2012, claims from out of network providers for Medically Necessary services that have been pre authorized will be reimbursed at 90% of the Medicaid fee schedule. However, claims for services not prior authorized will be denied. KSHP's clinical team is reviewing the Medicaid PA data provided and will be contacting providers to ensure that KSHP members who are currently receiving care under a Medicaid PA will continue to receive those authorized services. KSHP understands that some of the Medicaid PAs issued prior to November 1, 2011, may expire prior to December 1, 2011—KSHP will be willing to extend those authorizations and requests that practitioners provide the necessary clinical information to support requests for thee extensions. The requests for extension can be handled by telephone, Fax or through the Provider Web Portal. Additionally, KSHP has staff contacting providers contacting providers by phone or in person to review clinical data, training on KSSHP's authorization process, and assist with transition needs. This process is the same for individual practitioners and facilities. An MCO-assigned provider number is **not** required for submitting claims to Cenpatico. Providers are instructed to file claims using their National Provider Identifier (NPI) (special provisions apply to Impact Plus providers), taxonomy or Medicaid ID, and tax identification number (TIN). It is requested that Impact Plus providers file claims using a TIN and subprogram number assigned by the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) for services they are providing. Out of network providers who wish to start a new episode of behavioral health and/or substance abuse care for a KSHP member should contact **Cenpatico at 855-790-5056,** for prior authorization. If the out of network provider is not yet registered with Cenpatico, the necessary information will be obtained at that time. Remember: If a KSHP member requires inpatient (or outpatient) care/treatment beyond the Medicaid specified authorization time period, the provider must contact KSHP for an extension to that authorization. .
Physical Health	**<u>For KSHP Physical Health Practitioners</u>** Out of network providers will be reimbursed at 100% of the Medicaid fee schedule through December 31, 2011, for prior authorized services. Beginning Jan. 1, 2012, claims of out of network providers will be reimbursed at 90% of the Medicaid Fee schedule for Medically Necessary covered services provided to eligible KSHP members. However, claims for services not prior authorized will be denied. Out of network providers must obtain prior authorization for services; however, if an eligible a member

	meets InterQual criteria, KSHP will work with providers so that claims will be paid for Medically Necessary services during the transition of care period – the first 30 days beginning on November 1, 2011. KSHP will also use that opportunity to encourage the out of network provider to become a participating provider. Prior authorizations are not required for certain out of network services, including emergency care and routine X-ray and laboratory services. The prior authorization list may be found on the KSHP web site at www.kentuckyspirithealth.com. If in doubt, practitioners may call or use the KSHP Web tool which allows the practitioners to enter billing codes and receive a system response which will inform them whether the service(s) require(s) prior authorization. This system is available to in network/out of network providers. Both in network and out of network providers are required to use their NPI number and TINs for claims submitted to KSHP. The KSHP neither assigns, nor requires a KSHP specific provider ID number in order to submit claims. he Kentucky Medicaid number may also be included on the claim, but is not required KSHP's clinical team is reviewing the Medicaid PA data provided and will be contacting providers to ensure that KSHP members who are currently receiving care under a Medicaid PA will continue to receive the authorized services. KSHP understands that some of the Medicaid PAs issued prior to November 1, 2011, may expire prior to December 1, 2011 – KSHP will be willing to extend those authorizations and requests that practitioners provide clinical information to support their requests for the extensions. Those requests for extension may be handled by telephone, Fax, or through the Provider Web Portal. Additionally, KSHP staff will be contacting providers by telephone or in person to review clinical data, train on KSHP's authorization process, and assist with transition needs. This process is the same for individual practitioners and facilities. If the previously requested service is not available within KSHP's network and Medical Necessity criteria are met, the authorization will continue and KSHP Care Coordinators will provide assistance to the member and outreach to the provider for any additional care coordination needs. An out of network provider may provide new services to KSHP members by contacting the KSHP prior authorization (PA) department by telephone at **866-643-3153, or by Fax at 855-252-0564 or 855-252-0567**. The provider may access KSHP's PA list and PA form at www.kentuckyspirithealth.com. If during the transition of care period, an in or out of network provider has numerous requests for PA and faxes the requests to KSHP's PA department by 9 AM EST, KSHP will provide a decision relating to each PA request by Close of Business on the same day or by 9 AM EST of the following day. Remember: If a KSHP member requires additional care/treatment by a provider beyond the Medicaid specified prior authorization time period, the provider must contact KSHP for an extension to that authorization.