FAQ's for the "Prior Authorization" Provider Letter Dated July 14, 2006

1. Question: Will prior authorizations under the old criteria be honored if they were issued for dates August 1 or after?

   Answer: Any prior authorizations done prior to August 1 will be honored.

2. Question: How do I obtain prior authorization for date of service August 1st?

   Answer: SHPS will begin accepting and issuing prior authorizations for the new services that require prior authorization on August 1st. SHPS may also look at some cases retrospectively in the beginning.

3. Question: Are dental services currently in effect under the *KyHealth Choices* service limits?

   Answer: Yes. For each plan, children under age 21 are limited to two cleanings per 12 months and adults age 21 and older are limited to one cleaning per 12 months.

4. Question: Are Passport members subject to the new prior authorization requirements that will become effective on August 1, 2006?

   Answer: Passport members are excluded from *KyHealth Choices*. Please contact Passport for any prior authorization requirements.

5. Question: Who will the provider contact to request an extension of services when the limit has been reached?

   Answer: Please refer to the "*KyHealth Choices* Communication Resource Guide" attached to the July 14th "Prior Authorization" provider letter. A copy of the letter and communication resource guide will also be available on DMS's website at the following address: http://chfs.ky.gov/dms/kyhealthchoices.htm

6. Question: Who will be responsible for obtaining prior authorization for patients that require outpatient physical therapy? The physician writing the order, the outpatient facility, or both?

   Answer: The physician who orders the service is responsible for obtaining prior authorization.

7. Question: Is there going to be a site available for practitioners to confirm Interqual criteria?

Answer: Providers should continue to use the fax and phone prior authorization methods that are currently in place for obtaining PAs.

8. Question: How do we know what plan the member has been assigned?

   Answer: Providers may check the member's co-payment and benefit page on KyHealth Net. Providers may also call the automatic voice response (AVR) at 1-800-807-1301 for member information.

9. Question: What kind of information will need to be submitted to meet the new prior authorization requirements effective on August 1?

   Answer: SHPS will need the name of the service and medical information to substantiate the need for the requested service.

10. Question: How are soft limits over-ridden?

    Answer: The member's provider must submit medical information to demonstrate that the requested service is medically necessary and request prior authorization.

11. Question: Under the old rules for chiropractic services, prior authorization was required after the 12th visit to the same provider. Therefore, if a member has been receiving chiropractic services from the same provider and has not yet reached his or her 12th visit, is the member now required to get prior authorization for their next visit?

    Answer: Under the new requirements, prior authorization is required for each chiropractic visit regardless of whether the member has reached his or her limit.

12. Question: Since the new prior authorization requirements begin on August 1, 2006, does a member need prior authorization for those visits used from 7/1/06 forward?

    Answer: Authorization is needed for visits that occur August 1st and after.

13. Question: Will any previously used fax forms change?

    Answer: No

14. Question: Will EPSDT, First Steps, Impact Plus, etc., prior authorization processes be changing in the near future?

    Answer: We do not anticipate any changes to these programs at this time.

15. Question: Do the new prior authorization requirements apply to waiver providers? If not, should the waiver providers continue to utilize the current prior authorization process?

    Answer: No. Waiver services and the requirements for prior authorization of waiver services will not change. Providers will continue to submit requests for level of care and service prior authorization using the current process. Therapy limits will not apply to therapies that are covered by the waiver and included in the plan of care.

16. Question: Will waiver services be subject to Interqual?

    Answer: At this time, waiver services will be authorized based upon the criteria currently in the regulations.

17. Question: Can a member change to a different benefit plan?

    Answer: Each benefit plan to which a member has been assigned is based on the member's eligibility, type of services that the member receives, and current needs. If a member's medical needs or circumstances change, the department may assign the member to a more appropriate benefit package.

18. Question: Can a doctor refuse to see a member or a pharmacist refuse to fill a member's prescriptions if the member does not have his or her co-pay money?

    Answer: According to state law (KRS 205.6312[4]), "No provider participating in the Medical Assistance Program shall deny services to any eligible recipient due to the inability of a recipient to make the required copayment. This provision shall not excuse the recipient from liability for payment of the charge."

    Exception: Although KRS 205.6312 does not allow Medicaid providers to deny services for non-payment of cost-sharing charges, the 2006 budget bill (HB 380) states the following: "Notwithstanding KRS 205.6312(4), a pharmacy provider participating in the Medical Assistance Program shall not be required to serve an eligible recipient if the recipient does not make the required copayment at the time of service, except for an initial encounter when a recipient presents a condition which could result in harm to the recipient if left untreated, in which case the pharmacist shall dispense a 72 hour emergency supply of the required medicine. The recipient may then return to the pharmacy with the necessary copayment to obtain the remainder of the prescription. Only one dispensing fee shall be paid by the Cabinet for the provision of both the emergency supply and the remainder of the prescription."

19. Question: What happens to a member's health care if a member does not pay the dollar limit or co-payment?

Answer: If a recipient does not pay his or her cost-sharing charge, a provider (except for a pharmacist) is required to provide the service. However, non-payment of a cost-sharing charge does not relieve the recipient from his or her obligation to pay the co-payment or co-insurance fee. As mentioned previously, only a pharmacist may refuse to provide services based on non-payment of a cost-sharing charge. However, the pharmacist must dispense a 72 hour emergency supply of the required medicine if (during an initial encounter) a recipient presents a condition that could result in harm to the recipient if left untreated. The recipient may then return to the pharmacy with the necessary copayment to obtain the remainder of the prescription.

20. Question: Can a provider make an initial request for more visits than the service limitation?

Answer: No. A member must exhaust all visits before the service limit may be over-ridden.

21. Question: Will the services provided prior to 8/1 be subject to the new limitations in the *KyHealth Choice* plans?

Answer: Although the new prior authorization requirements are effective 8/1/06, services provided on or after 7/1/06 are subject to the service limits required by the *KyHealth Choices* plans.

22. Question: With the service limits being considered "soft" and "overridden" through a PA request, what type of documentation will be required to meet the medical necessity for a PA to be approved?

Answer: SHPS will need the name of the service and medical information to substantiate the need for the requested service.

23. Question: How does a provider know what dollar limits a member has met prior to providing additional services?

Answer: Providers may check the member's co-payment and benefit page on KyHealth Net. Providers may also call the automatic voice response (AVR) at 1-800-807-1301 for member information. Members can call 800-635-2570.