



# **PROVIDER MANUAL**

March 2015

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## 1.0 INTRODUCTION AND RESOURCES

### INTRODUCTION

Welcome to Kentucky Health Cooperative, Inc. (“KYHC”)! This Provider Manual presents a general overview of information from key areas including but not limited to:

- Administrative/Operations
- Credentialing
- Clinical Care Integration
- Quality Improvement
- Complaints and Appeals

It is the goal of KYHC to provide each network provider with valuable information needed to interact with us. We are committed to providing practitioners and facilities with an accurate and up-to-date manual; however, there may be instances where new processes are not immediately reflected in this manual. In such cases, KYHC will make every effort to provide updated documentation in future manual updates.

This Provider Manual is intended to support entities and individuals contracted with KYHC. Unless the context indicates otherwise, the use of the term “practitioner” within this manual refers to entities and individuals contracted with KYHC that bill using a CMS-1500 format. The use of the term “facility” generally refers to facilities and other entities contracted with KYHC that bill using a CMS-1450 (UB-04) format, such as acute care hospitals, outpatient surgery centers, and ambulatory surgery centers. The term “provider” is a more generic term which may be used to refer to both practitioners and facilities. Toward this end, reference to the terms such as “provider Web site”, “provider network”, “provider Inquiry” and similar terms apply to both practitioners and facilities.

### RESOURCES / CONTACT US

**KYHC Web site:** [www.mykyhc.org](http://www.mykyhc.org)

- Within the provider section of the Web site, the following information is available at a minimum:
  - Becoming a participating provider
  - Communications (*e.g.* newsletters, notifications and updates)
  - Forms (*e.g.* Electronic Data Interchange (EDI) Registration, Electronic Funds Transfer (EFT) set-up)
  - Frequently Asked Questions (FAQs)
  - Contact Us

#### **Mail medical claims and other correspondence to:**

Kentucky Health Cooperative, Inc.  
P.O. Box 9107  
Foxboro, MA 02035

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**Provider Portal:** <https://portal.mykyhc.org>

- KYHC's Provider Portal offers secure, self-service options to KYHC providers after registering online. All in-network providers will receive a letter from KYHC with registration information.
- Provider Portal registration procedures are as follows:
  - Visit <https://portal.mykyhc.org>
  - Click on New Provider User to register
  - Complete the self-registration form
  - You will need 4 pieces of information in order to complete your registration:
    - provider name as it is registered with KYHC (included in your registration letter)
    - PIN number (included in your Registration Letter)
    - National Provider Identifier (NPI)
    - Federal Tax Identification Number (TIN)
- The initial self-registration should be performed by the member of your staff responsible for managing additional users on your account, such as your office manager. Once this person registered, they will be allowed to add new users.
- Provider self-service options include at a minimum: eligibility verification, medical claim status, complaints, and remittance advice information.

**Interactive Voice Recognition (IVR) System:**

- KYHC's Interactive Voice Response (IVR) system may be accessed by calling **1-855-OUR-KYHC (1-855-687-5942)**. The IVR system is available to all participating KYHC providers to telephonically verify member eligibility and check claims status 24 hours a day / 7 days a week. To access the IVR system, the following information is required: NPI; member ID; date of service; billed amount. This information is updated daily and provides a rapid way to obtain claim status.

**KYHC Provider Services Support Line: 1-855-OUR-KYHC (1-855-687-5942)**

- Please use the KYHC Provider Services Support Line to contact KYHC's provider call center, where you may speak with a call center agent for questions regarding eligibility verification, medical claims status, reviews or submissions or complaints.
- KYHC provider call center hours of operation are:
  - Monday – Friday 8 a.m. to 7 p.m. Eastern Time
  - Saturday 8 a.m. to 2 p.m. Eastern Time

**Provider Services Email:** [providerservices@mykyhc.org](mailto:providerservices@mykyhc.org)

- Every KYHC provider has an assigned a KYHC Provider Services Representative who is available to assist with: (a) training requests; (b) questions or issues related to contracts; and (c) complex or escalated issues that cannot be resolved by the KYHC Provider Call Center. Assignment of a KYHC Provider Services Representative is based on the county in which the provider is located. In the event you are unable to reach a Provider Services Representative directly by telephone, they also respond to email and voicemail inquiries. See Appendix A to this Provider Manual for Provider Services Representative territories and contact information.

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**KYHC Clinical Care Integration Services: 1-855-635-5580**

- To request prior authorizations, utilization management, case management, disease management and quality improvement or review, contact KYHC's Clinical Care Integration (CCI) Department.
- CCI hours of operation are:  
Monday – Friday 8 a.m. to 5 p.m. Eastern Time
- For your convenience, Utilization Management team hours of operation are:  
Monday – Friday 8 a.m. to 6 p.m. Eastern Time

**Provider Pharmacy Help Desk: ProCare: 1-888-821-5517**

- KYHC has contracted with ProCare Rx for Prescription Pharmacy Services. To access the KYHC Formulary, visit [www.mykyhc.org](http://www.mykyhc.org). ProCare also has a 90-day mail order pharmacy program available.

**Mental Health and Substance Abuse Services: MHNet: 1-855-309-2422**

- KYHC has contracted with MHNet for Mental Health and Substance Abuse Services. For MHNet provider services, prior authorizations and claims management, contact MHNet at: **1-855-309-2422**
- For additional information, refer to [www.mhnet.com](http://www.mhnet.com).

**Pediatric Vision Benefit: Avēsis: 1-866-524-8544**

- KYHC. has contracted with Avēsis for services relating to the pediatric vision benefit. For provider services, claims inquiries, *etc.*, please contact Avēsis at **1-866-524-8544**
- Avesis provider services representatives are available to assist you from 7:00 a.m. to 8:00 p.m. Eastern Time Monday through Friday. You may also visit the Avēsis website at [www.avēsis.com](http://www.avēsis.com) for additional information.

## 2.0 CREDENTIALING/REREDENTIALING

### SCOPE

To provide members of Kentucky Health Cooperative Inc. (“KYHC”) with the best medical care possible, KYHC’s provider network, known as the KYHC Care Network, is comprised of a wide array of providers of various specialties and backgrounds. These providers are carefully selected and screened prior to acceptance in the KYHC Care Network. This screening process is referred to as provider credentialing. KYHC conducts credentialing and recredentialing utilizing National Committee for Quality Assurance (NCQA) standards.

The medical practitioner disciplines eligible for participation on KYHC’s panel of participating providers are:

- Physicians: Allopathic and Osteopathic
- Oral Surgeons
- Chiropractic Physicians
- Podiatric Physicians
- Nurse Practitioners
- Physician Assistants
- Clinical Dieticians
- Physical Therapists
- Other master’s or doctoral level licensed clinicians

In order to become a participating provider in the KYHC Care Network, each practitioner must be part of a practice or organization which has signed either a physician group participation agreement; a physician organization participation agreement; a hospital participation agreement; or an ancillary services participation agreement. The practitioner must complete a provider application and must meet all eligibility criteria.

### PRACTITIONER APPLICATION

KYHC’s practitioner application includes the following:

- Practitioner information
- Practice information
- Professional liability insurance information
- Education and training
- Work history
- Hospital privileges
- Clinical information including clinical experience and:
  - Populations served
  - Disorders treated
  - Specialty areas
  - Cultural and language specialty areas
  - Languages spoken by practitioner
  - Languages spoken by office staff
- Questions that address:
  - The reason(s) for any inability to perform the essential functions of the position with or without accommodation
  - Illegal drug use
  - History of loss of license and felony convictions
  - History of loss or limitation of privileges or disciplinary activity
  - Current malpractice insurance coverage
- Attestation as to correctness and completeness of the application

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## APPLICATION PROCESS

A packet of credentialing information, including application information, will be provided to each practitioner or group during the completion of the contracting process. All practitioners are encouraged to complete and submit the application and supporting documentation promptly to avoid any delay in their participation status. KYHC encourages all practitioners seeking to become participating with KYHC to utilize the Council for Affordable Quality Healthcare (CAQH) application process in lieu of using a paper application. This will greatly improve the turn-around time of the credentialing process. Practitioners needing additional information about how to sign up for CAQH may contact KYHC's credentialing staff via email at [providercredentialing@mykyhc.org](mailto:providercredentialing@mykyhc.org) or contact the KYHC Provider Services Representative for your area.

If already participating with CAQH, please ensure that all information is up to date prior to the beginning the credentialing process. All practitioners must successfully complete the credentialing process and be approved before being admitted for participation in the network.

Upon receipt of a completed credentialing packet from a practitioner, KYHC credentialing staff will perform an initial review to ensure that the necessary documents have been received and appear to be complete. In the event additional information or clarification is needed, the packet will be returned to the practitioner with a request for the additional information. Practitioners must respond by providing the needed information within 15 days of receiving the request. If the requested information is not received, the credentialing process will be halted.

## PRIMARY SOURCE VERIFICATION

Primary source verification is an integral part of the credentialing process. KYHC will verify the following:

- The practitioner has an active unrestricted professional license.
- Drug Enforcement Administration (DEA) registration for all physicians and for Practitioners with prescribing ability in the state in which they treat KYHC members.
- Controlled Dangerous Substance (CDS) certificate for all physicians and for practitioners with prescribing ability in the state in which they treat KYHC members, if appropriate.
- Education, training and board certification for physicians.
- Education and training, and board certification if appropriate, for non-physicians.
- Work history.
- Information about professional liability (malpractice) insurance coverage through attestation by the practitioner that he or she has current malpractice insurance coverage in the required limits established by KYHC.
- Malpractice history.
- Information about Medicare and Medicaid sanctions.
- Information about sanctions, restrictions or limitations on a practitioner's professional license.
- Information about clinical privileges for physicians through attestation by the practitioner regarding current privileges and any history of loss or limitation of clinical privileges or disciplinary action(s).

Credentials and other relevant information must be verified and available for review by the KYHC Credentialing Committee before the committee makes a decision to credential or re-credential a practitioner. KYHC credentialing staff must follow established timelines concerning credentialing and presentation to the Credentialing Committee.

The following credentials must be verified within 180 days of presentation to the Credentialing Committee:

- Professional license
- Board certification
- Malpractice history
- Information on state sanctions, restrictions on licensure or limitations on scope of practice
- Information on Medicare and Medicaid sanctions

The following credentials and other information require verification in the 365 calendar day period directly preceding the Credentialing Committee decision date:

- Work history
- Application and current and signed attestation regarding:
  - Reason(s) for any inability to perform the essential functions of the position, with or without accommodation
  - Illegal drug use
  - History of loss of license and felony convictions
  - History of loss or limitation of privileges or disciplinary activity
  - Current malpractice insurance coverage
- The correctness and completeness of the application

The following are credentials that must be valid and in effect at the time of the Credentialing Committee decision:

- Professional license
- DEA registration for all physicians and for non-physician practitioners with prescribing ability in the state in which they treat KYHC members
- CDS certificate for all physicians and for non-physician practitioners with prescribing ability in the state in which they treat KYHC members, if applicable in the state in which the practitioner practices

All credentials that have a verification time limit will be re-verified and updated if the time limit will be exceeded on the date of the Credentialing Committee decision. The same sources used to initially verify the credentials are used to re-verify the credentials. All practitioners found to meet all KYHC criteria will be approved for participation by either KYHC's Chief Medical Officer or KYHC's Credentialing Committee.

## ASSESSMENT OF FACILITIES

Each medical facility must meet the criteria established by KYHC to participate in the network.

The types of medical facilities considered for participation in KYHC's network include:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing surgical centers

KYHC's criteria for facility network participation include:

- A state license, if applicable in the jurisdiction where the facility is located that designates the facility as a treatment facility
- Confirmation that the facility is in good standing with state and federal regulatory bodies
- Accreditation by an accrediting organization recognized by KYHC. KYHC recognizes the following accrediting organizations:
  - The Joint Commission (TJC)
  - The Commission on Accreditation of Rehabilitation Facilities (CARF)
  - The Council on Accreditation of Services for Families and Children, Inc. (COA)
  - Det Norske Veritas (DNV)

An on-site assessment may be necessary for facilities that are not accredited by an accrediting organization recognized by KYHC. In certain situations a site visit conducted by state or federal regulatory authorities may be accepted in lieu of an on-site assessment conducted by KYHC providing that the assessment meets certain criteria.

## CREDENTIALING COMMITTEE

KYHC's Credentialing Committee is heterogeneous and multidisciplinary comprised of a broad range of participating practitioners as members. KYHC ensures that Credentialing Committee decisions are not based on an applicants' race, ethnic or national identity, gender, age, sexual orientation, or on the type of procedure or patient which the Practitioner is treating.

## NOTICE OF DECISION AND CORRECTION OF INFORMATION

KYHC ensures practitioners are informed when information which they submit for credentialing and information which is collected in the verification process varies. Practitioners may correct erroneous information; review information collected in the application/reapplication process; and receive information about the status of their application by contacting KYHC's credentialing staff via email at: [providercredentialing@mykyhc.org](mailto:providercredentialing@mykyhc.org).

Practitioners will be notified in writing of the initial Credentialing Committee decision within 60 days of the Committee decision. If a Practitioner is denied participation, the notification will obtain the reason for the denial as well as all information regarding the right to appeal and details regarding the appeal process.

## RE-CREDENTIALING

All participating providers in the KYHC Care Network will be re-credentialed every 36 months.

The individual listed in KYHC records as the credentialing contact for each practitioner or facility will be notified 30 days in advance of the start of the re-credentialing process. All necessary information will be re-verified following the same processes as initial credentialing. If any additional information is needed during the re-credentialing process, the credentialing contact for the practitioner or facility will be contacted by phone or in writing to advise of the need.

## ONGOING MONITORING

KYHC conducts ongoing monitoring at appropriate intervals between re-credentialing cycles of all practitioners for:

- Medicare and Medicaid sanctions
- State sanctions or limitations on Professional Licensure
- Practitioner-specific member complaints
- Identified adverse issues

## TERMINATION

On occasion it may be necessary for KYHC to terminate a practitioner from the KYHC Care Network. Decisions about altering a practitioner's relationship with KYHC are based on defined, procedurally just processes to ensure that alterations to a practitioner's participation with KYHC are handled in a systematic and just manner, consistent with KYHC's participation agreements and affording the practitioner due process.

## TERMINATION WITH CAUSE

KYHC may opt to terminate a practitioner with cause. This may occur in situations such as:

- A confirmed serious quality of care issue is identified by KYHC
- The practitioner's professional license or other legal credential authorizing him or her to practice in any state or jurisdiction is revoked or suspended
- The practitioner's DEA registration or CDS certificate is revoked or suspended

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- Professional review action(s) by any of the following:
  - State or jurisdiction issuing a professional license or otherwise certifying the practitioner for independent practice
  - Federal agencies
  - Professional organizations
  - Other regulatory organizations
  - Violations of KYHC's participation agreement or KYHC's guidelines
  - Failure to comply with the terms of a corrective action plan
  - Material misrepresentation of information on the application for participation
  - Cancellation or failure to renew or maintain professional liability insurance in the amounts acceptable to KYHC
  - The practitioner is convicted of a felony

In the event a practitioner is being considered for termination with cause, all issues involved will be thoroughly reviewed by KYHC's Credentialing Committee. Based upon the results of that review, the committee may recommend any of the following:

- Determine that no action is required
- Impose routine corrective action
- Recommend to the Board of Directors that the practitioner's participation agreement be terminated with cause.

The final decision to terminate a practitioner with cause is made by KYHC's Board of Directors. The practitioner will be notified, via certified mail, of this decision along with reasons and the right and process to appeal the action.

## ROUTINE CORRECTIVE ACTION

Routine corrective action is initiated whenever the activity or professional conduct of a practitioner is, or is reasonably likely to be, detrimental to patient safety or to the delivery of quality and cost effective care or service. Routine corrective action may include: a verbal warning, a written warning, the implementation of a corrective action plan, or probation.

If corrective action is imposed, the Credentialing Committee will monitor compliance with the terms of any routine corrective action and performance after the imposition of any routine corrective action. If the practitioner does not alter the performance or behavior that is the cause for the routine corrective action or fails to comply with terms of the corrective action plan, a progressively more severe routine corrective action is imposed.

If a practitioner persists in not altering the performance or behavior that was the cause for the routine corrective action, termination with cause may be recommended by the Credentialing Committee.

## SUMMARY SUSPENSIONS

Summary suspension is imposed whenever a practitioner's conduct requires immediate action to prevent harm to members or reduce the substantial likelihood of immediate danger to the health or safety of members. If a summary suspension takes place the practitioner will be notified via certified mail or confirmed facsimile transmission. A summary suspension is effective immediately. KYHC's Credentialing Committee will investigate the incident that led to the summary suspension and may take any of the following actions:

- Impose a corrective action plan
- Remove the summary suspension
- Continue the suspension for a defined time
- Recommend termination with cause to KYHC's Board of Directors

## AUTOMATIC SUSPENSIONS

Automatic Suspension is deemed to occur immediately upon the occurrence of any one of the following events:

- The practitioner's professional license or other legal credential authorizing him or her to practice in the state or other jurisdiction where the practitioner treats KYHC members is revoked or suspended
- The practitioner's DEA registration or CDS certificate is revoked or suspended
- The practitioner is convicted of a felony

KYHC's Credentialing Committee will investigate the incident that led to the automatic suspension and may take any of the following actions:

- Impose a corrective action plan
- Remove the automatic suspension
- Continue the suspension for a defined time
- Recommend termination with cause to KYHC's Board of Directors

## PRACTITIONER AND FACILITY AVAILABILITY STANDARDS

In addition to ensuring, through the credentialing process, that all KYHC Care Network Providers meet the established standards for participation in the network, KYHC will also continually monitor the network itself to ensure that the number of Providers in the network is adequate to provide services to KYHC Members throughout the state.

## 3.0 PROVIDER DIRECTORY AND DEMOGRAPHIC INFORMATION

### KYHC PROVIDER DIRECTORY

Kentucky Health Cooperative, Inc. ("KYHC") makes available on its Web site various provider directory / provider search tools which can be accessed by KYHC providers and members to assist in locating participating providers in given specialties or locations. Separate provider directory / provider search tools are available on the Web site for medical providers; pharmacy providers; mental health and substance abuse providers; and pediatric vision benefit providers.

It is the responsibility of each participating provider in the medical category to notify KYHC of any changes in demographic information so that the information in the provider directory / provider search tool directory is complete, accurate, and up-to-date. Participating providers in the pharmacy category must notify ProCare of changes in demographic information; providers in the mental health and substance abuse category must notify MHNet of changes in demographic information; and providers in the pediatric vision benefit category must notify Avesis of changes in demographic information.

**You may access KYHC's provider directory / provider search tools at: [www.mykyhc.org](http://www.mykyhc.org).**

If you do not have internet access, contact the provider call center at **1-855-OUR-KYHC (1-855-687-5942)** for assistance in identifying network practitioners and facilities.

### NOTIFICATION OF INFORMATION CHANGES

Information submitted to KYHC during the contracting and credentialing processes will serve as the information of record in KYHC's systems and be used for several purposes, including production of KYHC's provider directory / provider search tool. It is imperative that information be complete, accurate and up-to-date at all times. If a provider has a change applicable to the entire practice, such as a demographic change (*e.g.* office address change, phone number change, adding a location) or addition of practitioner staff, KYHC must be notified promptly.

The credentialing contact designated on the Provider Information Form (PIF) will be notified in writing of the credentialing decision. Upon receipt of the approved credentialing decision letter, information relating to providers approved for participation may be displayed in KYHC's provider directory.

A copy of the Provider Information Form can be found in the provider resource library on KYHC's Web site, [www.mykyhc.org](http://www.mykyhc.org). Practices with more than five (5) practitioners who wish to submit their information via roster in lieu of the Provider Information Form should contact their designated KYHC Provider Relations Representative to discuss format and data requirements for the roster.

If additional practitioners are added to a practice, a Provider Information Form needs to be submitted -- along with a copy of the practice's Form W-9 -- by email to [providercredentialing@mykyhc.org](mailto:providercredentialing@mykyhc.org) or by fax to **(502) 272-4587** to the attention of KYHC's Provider Services Department. If a practice has a demographic change for the practice, such as an address change, phone number change, or addition of a location, the practice should notify KYHC as soon as possible of the change.

For demographic changes, KYHC can be notified by completing the Provider Demographic Change Request Form and submitting the form by email to [providercredentialing@mykyhc.org](mailto:providercredentialing@mykyhc.org) or by fax to **(502) 272-4587** to the attention of the Provider Services Department.

## NETWORK SERVICE AREA AND IN-NETWORK DESIGNATION

KYHC's Network Service Area is comprised of:

- All 120 Counties in the Commonwealth of Kentucky *plus*
- Selected counties in states bordering the Commonwealth of Kentucky:

| Illinois  | Indiana     | Missouri    | Ohio     | Tennessee  | Virginia  | West Virginia |
|-----------|-------------|-------------|----------|------------|-----------|---------------|
| Alexander | Clark       | Mississippi | Adams    | Campbell   | Buchanan  | Cabell        |
| Gallatin  | Crawford    | New Madrid  | Brown    | Carter     | Dickenson | McDowell      |
| Hardin    | Dearborn    |             | Clermont | Clay       | Lee       | Mingo         |
| Massac    | Floyd       |             | Hamilton | Claiborne  | Wise      | Wayne         |
| Pope      | Harrison    |             | Lawrence | Davidson   |           |               |
| Pulaski   | Jefferson   |             | Scioto   | Pickett    |           |               |
|           | Ohio        |             |          | Henry      |           |               |
|           | Perry       |             |          | Knox       |           |               |
|           | Posey       |             |          | Lake       |           |               |
|           | Spencer     |             |          | Macon      |           |               |
|           | Switzerland |             |          | Montgomery |           |               |
|           | Vanderburgh |             |          | Obion      |           |               |
|           | Warrick     |             |          | Robertson  |           |               |
|           |             |             |          | Scott      |           |               |
|           |             |             |          | Stewart    |           |               |
|           |             |             |          | Sullivan   |           |               |
|           |             |             |          | Sumner     |           |               |
|           |             |             |          | Washington |           |               |
|           |             |             |          | Weakley    |           |               |

Covered Services provided by In-network providers will be paid at In-network benefit levels. Effective January 1, 2015, health care providers in the First Health Network who are located outside KYHC's Network Service Area, will be considered "in-network" solely for emergency care and urgent care services.

To determine a given Provider is considered In-network for the member's KYHC plan follow the steps below:

1. From the [www.mykyhc.org](http://www.mykyhc.org) main page, click on the provider directory search link. This link will direct the user to the various provider directory / search tools.
2. Choose how to search for the provider: zip code, state, county, city, or specialty area.
3. Enter the appropriate information or select from the drop down boxes and select "GO."
4. After the results appear, if you wish to narrow your search results, use the options available at the top of the page to reduce the results to only those within a certain geographic range of your zip code, type of provider, or specialty. Note: the search bar at the top of the page can be used to search specifically for a provider by name or specialty or condition that the provider would treat.
5. To create a copy of this directory that will be sent to the email address entered, select the option to create a directory. Additionally, a printed copy of the search results can be achieved by clicking the printer icon.

### Helpful Hints:

- Avoid using professional titles when searching by name. When searching for Dr. Jane Doe, do not use Dr. as a part of your search.
- The look-up tool allows a search using a partial name. If unsure of a spelling, use the portion of the known name and narrow your results down afterwards.
- For difficulty locating a provider using one search method, consider trying a second method. For example, if looking for Dr. Jane Doe (an endocrinologist in Jefferson County) by name proves unsuccessful, do an additional search for providers by county and select endocrinology as the specialty to narrow down the search.
- Utilize the features of the look-up tool to narrow down the results based upon need.
- If having issues navigating the look-up tool, click on the “Help” option and review the additional material available.
- If having difficulty locating a provider or utilizing the provider look-up tool, customer service agents in the KYHC provider call center are available to assist by calling **1-855-OUR-KYHC (1-855-687-5942)**.

## 4.0 ADMINISTRATIVE AND LEGAL COMPONENTS

### MEMBER RIGHTS AND RESPONSIBILITIES

Kentucky Health Cooperative Inc. ("KYHC") members have the right to . . .

- Receive information about KYHC, as well as KYHC services, providers and their rights and responsibilities.
- Be treated with respect and with due consideration for their dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to their condition(s) and ability to understand.
- An open discussion of appropriate or medically necessary treatment options, regardless of cost or benefit coverage.
- Participate with practitioners in decisions regarding their health care, including the right to refuse treatment.
- Voice complaints or appeals about the organization or the care it provides.
- Make recommendations about these Member Rights and Responsibilities.
- Have timely access to covered services.
- Have services available 24 hours a day, seven days a week when such availability is medically necessary.
- Direct access to women's health specialists for routine and preventive care, including family planning, annual women's tests, and OB service without approval by KYHC or their doctor.
  - o This includes birth control, HPV tests, Chlamydia tests, and annual pap tests.
- Receive written notice of a decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested (partial denial). Members will receive this information as quickly as needed so that their medical needs are met and treatment is not delayed.

Kentucky Health Cooperative Inc. members have the responsibility to . . .

- Provide information (to the extent possible) needed by KYHC, its practitioners, and other healthcare providers so that the providers can properly care for the members.
- Follow plans and instructions for care which upon which they have agreed with their health care practitioners.
- Understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.

### PRIVACY STATEMENT

Kentucky Health Cooperative, Inc. ("KYHC") is committed to appropriately protecting and managing any personal information shared with us. KYHC provides this Privacy Statement to describe information practices and the choices made about the way information is collected and used.

Personal information collected by KYHC will be stored and processed in the United States. KYHC complies with the U.S. Commerce Department's Safe Harbor Framework and certifies its adherence to the Safe Harbor Privacy Principles. More information about the Safe Harbor Program can be found at: <http://export.gov/safeharbor>.

### WHAT INFORMATION WE COLLECT

This Privacy Statement applies to all personal information collected by or submitted to KYHC (or carefully selected third parties acting on KYHC's behalf). "Personal information" is data that reasonably can be used to identify or describe an individual. Personal information is not required to simply to browse our website.

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KYHC collects personal information when:

- you enroll in a health insurance plan;
- you register online for seminars or special events;
- you request customer support;
- you create a user account (login username and password);
- you request information or materials (e.g., whitepapers or newsletters);
- you participate in surveys and evaluations;
- you apply for a job or submit your resume; or
- you submit questions or comments to us.

The types of personal information collected may include (but are not limited to):

- your first and last name;
- your title and your company's name;
- your home, billing, or other physical address (including street name, name of a city or town, state/province, postal code);
- your email address;
- your telephone number;
- (for job applicants submitting electronic information) your educational background, employment experience, and job interest;
- any other identifier that permits KYHC to make physical or online contact with you; or
- any information that KYHC collects online from you and maintains in association with your online account, such as your KYHC username and password.

In addition, the Web site used by KYHC automatically gathers general statistical information about the site and visitors, such as IP addresses, browsers, pages viewed, number of visitors, goods and services purchased, etc., but in doing so, KYHC does not reference you by individual name, email address, home address, or telephone number. KYHC uses this data in the aggregate to determine how much users use parts of our Web site so that KYHC can make improvement to the site. KYHC may provide this statistical information to third parties, but when doing so KYHC does not provide personally-identifying information without your permission.

As part of KYHC's Web site services, it uses cookies to store and sometimes track information about you. Some features of the Web site may be available only through the use of a cookie. A cookie is a small amount of data that is sent to your browser from a Web server and stored on your computer's hard drive. Generally, KYHC uses cookies to remind us who you are and to enable us to access your account information so you do not have to re-enter it, gather statistical information about usage by registered or unregistered users to research visiting patterns and to help target advertisements based on user interests, assist our retail partners to track visits and process orders, and track progress and participation in promotions and other services. Preference and options configurations in your browser determine if and how a cookie will be accepted. You can change those configurations on your computer if you desire. By changing your preferences, you can accept all cookies, you can be notified when a cookie is sent, or you can reject all cookies. If you do so and cookies are disabled, you may be required to re-enter your information more often, and certain features of our site may be unavailable.

In addition, our retail partners, advertisers, and other third parties appearing at the Web site or linked to the site may use their own cookies and may collect personally-identifiable information, including credit card information, in connection with your use of their Web sites. The privacy policy of such third parties may differ from the policy of KYHC. We encourage you to read the third party's privacy policy before responding to the offer to determine how the personally-identifiable information is used by that third party.

## HOW WE USE YOUR INFORMATION

KYHC collects and uses your personal information to operate and improve its operations, to fulfill your requests for information, to enroll you in a health insurance plan or program, to process your job application, to provide you educational materials, to provide service and support, and to carry out the transactions you have requested. These uses may include providing you with more effective customer service, making the Web sites or services easier to use by eliminating the need for you repeatedly to enter the same information, performing research and analysis aimed at improving our products and services, and displaying content customized to your interests and preferences.

We also use your personal information to communicate with you. We may send certain mandatory service communications such as welcome letters, billing specifics, information on technical service issues, and enrollment announcements. Some KYHC services may send periodic member letters that are considered part of the service. Personal information collected online may be combined with information you provide KYHC in other ways, such as through new member welcome calls, flu shot reminder calls, etc.

## HOW WE SHARE YOUR INFORMATION

KYHC keeps your personal information confidential. We will not sell, rent, or lease your personal information to others. Unless we have your permission, we will not use or share your personal information in ways unrelated to the ones described at the time you provide the data. KYHC engages service providers and suppliers ("agents") to perform certain functions on KYHC's behalf. For example, these agents may provide health insurance plan service and support, maintain KYHC information technology systems, and assist KYHC with education and outreach and communication initiatives. Those agents will be permitted to obtain only the personal information they need to perform the services. They are required to maintain the confidentiality of the information received on KYHC's behalf and are prohibited from using it for any other purpose.

We may access and/or disclose your personal information if we believe such action is necessary to: (a) comply with law or any legal process served on KYHC, (b) comply with requests for information from police or government authorities, (c) protect and defend the rights or property of KYHC (including the enforcement of our agreements), or (d) act in urgent circumstances to protect the personal safety of KYHC employees or members of the public.

KYHC will NEVER SHARE your protected health information unless you give us written permission for either of the following:

- Marketing purposes
- Sale of your information

## YOUR CHOICES

KYHC offers you the opportunity to choose whether your personal information is (a) to be disclosed to a non-agent third party or (b) to be used for a purpose other than the purpose for which it was originally collected or subsequently authorized by you. KYHC will provide you reasonable mechanisms to exercise your choices at the data collection point or by using other methods.

These choices are not applicable to communications from KYHC primarily for the purpose of support or other administrative and transactional notices.

## HOW YOU CAN KEEP YOUR INFORMATION ACCURATE

KYHC strives to keep your personal information accurately recorded. We have implemented technology, management processes, and policies to help maintain data accuracy. KYHC provides individuals with reasonable access to review and correct their personal information. Contact us by sending an email request to [privacy@mykyhc.org](mailto:privacy@mykyhc.org). We will make reasonable efforts to make necessary corrections. To protect your privacy and security, we will also take reasonable steps to verify your identity before granting access to or making alterations to data we maintain.

## KEEPING YOUR PERSONAL INFORMATION SECURE

To protect against unauthorized access, misuse, disclosure, or alteration of your personal information, KYHC employs appropriate physical, technical, and administrative measures. Physical security is designed to prevent unauthorized access to database equipment and hard copies of documents. Electronic security measures, such as firewalls, access restrictions, and encryption provide protection from hacking or other unauthorized access. KYHC limits access to personal information to those persons in KYHC's organization, or to agents of KYHC, who have a specific business purpose for maintaining and processing personal information and data.

To use some of KYHC's services, you may be required to set up a password-protected account or profile on our Web site. KYHC recommends that you do not divulge your password to anyone. It is your responsibility to keep your password protected. KYHC personnel will never ask you for your password in an unsolicited phone call or in an unsolicited e-mail. Remember to sign out of your account, close your browser window, and delete your temporary Internet files when you have finished your session. This helps ensure that others cannot access your personal information and correspondence if you share a computer with someone else or are using a computer in a public place where others may have access to it.

Whenever you voluntarily disclose personal information online -- for example, on message boards, through e-mail or in chat areas -- that information can be collected and used by others. No data transmission over the Internet or any wireless network can be guaranteed to be perfectly secure. As a result, while we try to protect your personal information, we cannot ensure or guarantee the security of any information you transmit to us, and you do so at your own risk.

## CHILDREN UNDER 13

KYHC has no way of distinguishing the age of individuals who access the Web site, and so KYHC carries out the same Privacy Policy for individuals of all ages. If a child has provided KYHC with personally-identifying information without parental or guardian consent, the parent or guardian should contact us to remove the information and opt out of promotional opportunities or other applicable services.

## ENFORCEMENT

KYHC will regularly review its compliance with this Privacy Statement. Please feel free to direct any questions or concerns regarding this statement or KYHC's treatment of personal information by contacting us at the link or address indicated below. When we receive written questions and concerns at this address, it is KYHC's policy to contact the individual user regarding his or her concerns. We will investigate and attempt to resolve concerns regarding use and disclosure of personal information in accordance with the principles contained in this statement.

Any concern that cannot be resolved through our internal processes will be settled by arbitration administered by the American Arbitration Association (AAA) in accordance with its applicable commercial rules and, as applicable, the Safe Harbor Principles. The exclusive location for such arbitration shall be Louisville, Kentucky. All decisions of the arbitrator(s) will be final and binding on the parties, which waive any right to further appeal the arbitration award, to the extent an appeal may be lawfully waived. By using this Site and disclosing any personal information to KYHC, you agree to adhere to and be bound by this dispute resolution process.

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## LINKS TO OTHER SITES

Some pages on KYHC's Web site may contain links to third-party websites. KYHC does not endorse and has no control over the privacy practices or content of such Web sites. We recommend you carefully read the privacy policies of each site you visit.

## CONTACTING US

If you have comments or questions regarding this Privacy Statement, please send them to [privacy@mykyhc.org](mailto:privacy@mykyhc.org) or write to us at the following address:

Kentucky Health Cooperative, Inc.  
Privacy Mailbox  
9700 Ormsby Station Road, Suite 100  
Louisville, KY 40223

## CONSENT AND AGREEMENT

By using KYHC's Web site or other services, you signify your agreement to the terms and conditions of this Privacy Statement. If you do not agree to these terms and conditions, please do not disclose any personal information to KYHC's Web site.

## CHANGES TO THIS STATEMENT

If KYHC changes this Privacy Statement, we will post the revised statement here, along with the date of revision. If we make significant changes to the Privacy Statement, we may also post a notice on our home page. Any changes will apply only from date of the revision. Amended dispute resolution provisions will not apply to any dispute of which the parties had actual notice as of the date of the amendment.

## PROTECTED HEALTH INFORMATION ("PHI")

Defined as including any health information about a specific individual that is transmitted or maintained in any form or medium including oral, paper, or electronic.

"Ability to Identify an Individual" – If a reasonable person, not approved to receive the respective PHI, could identify an individual from the information disclosed then there is an unacceptable potential for an impermissible disclosure. Best practice is to avoid disclosure of demographic information, information related to past or present medical condition, specific medications et al.

Practitioners and facilities are required to review all member information received from KYHC to ensure no misrouted PHI is included. Misrouted PHI includes information about members that a practitioner or facility is not currently treating. PHI can be misrouted to practitioners and facilities by mail, fax, email, or electronic remittance. Practitioners and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are practitioners or facilities permitted to misuse or re-disclose misrouted PHI. If practitioners or facilities cannot destroy or safeguard misrouted PHI, practitioners and facilities must contact Provider Services to report receipt of misrouted PHI.

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## PRACTITIONER AND FACILITY MEDICAL RECORDS

On occasion, KYHC may request on-site, electronic or hard copy medical records, utilization review sheets and/or itemized bills related to claims for the purposes of conducting audits and reviews to determine medical necessity, diagnosis and other coding and documentation of services rendered.

In order to allow for effective patient care and quality review, KYHC requires that all providers maintain medical records which are current, detailed, and organized. Medical records shall be available to health care practitioners at each patient visit and to recognized state and national reviewing bodies upon request. This includes reviewing bodies sanctioned by the Commissioner of Insurance of the state in which the practitioner provides health care services. Medical records shall also be available for review upon request by KYHC members and KYHC staff.

KYHC has set the following minimum standards for practitioner medical record keeping. These standards address medical record content, organization, and confidentiality:

- Practitioners must keep accurate, and complete medical records including but not limited to radiology and laboratory tests, results of examinations and notes that document all medical services received by the member, including inpatient, ancillary, and emergency care.
- Medical records must be prepared in accordance with applicable State and Federal rules and regulations and must be signed by the medical professional rendering the services.
- Medical records must be accessible at the site of the member's participating primary care physician or provider.
- To ensure the member's privacy, medical records should be kept in a secure location and only accessed by authorized personnel.
- Practitioner's staff must receive periodic training in medical record confidentiality.
- Practitioners are required to maintain all records for members for at least 10 years for adult patients and 13 years for minors.

KYHC will periodically assess medical record keeping practices for network practitioners against the established standards listed above. This assessment may take place in the form of a review of a sample of files. This sample could be selected as a part of a HEDIS review and may include files that did not pass HEDIS or other audits, or it could take place based on past documentation of deficiencies. A practitioner may also be selected throughout the year for one or more focused chart review(s) to include utilization review, quality management, medical claim review, or member complaint/appeal investigation.

## 5.0 MEMBER ELIGIBILITY AND BENEFITS DETERMINATION

### DETERMINING ELIGIBILITY

It is the responsibility of each provider to check eligibility prior to each patient visit or prior to rendering services to KYHC members. The presentation of a KYHC member Identification Card does not guarantee current eligibility. Providers will be able to verify member eligibility using one of four (4) methods.

Please have a copy of the member's identification card which will provide the necessary identifiers.

1. Secure Web Portal – KYHC offers a secure web portal for providers to utilize to verify eligibility. **Providers may access the portal at <https://portal.mykyhc.org>.**  
Providers must enter the exact name on file with KYHC, a PIN assigned by KYHC, their NPI, and Tax ID to register for the portal. If you have not received this information, please call KYHC's provider call center at **1-855-OUR-KYHC (1-855-687-5942)** and a representative will assist you.  
Once you have registered for the portal, navigate to patient, member eligibility search, and enter the member's name, Date of Birth (DOB), and member ID as well as the Date of Service (DOS) for the person for which you are verifying eligibility.
2. Interactive Voice Response (IVR) – please call **1-855-OUR-KYHC (1-855-687-5942)** and follow the prompts to validate a member's eligibility.
3. Provider Call Center Agent – please call **1-855-OUR-KYHC (1-855-687-5942)** and a provider call center agent will assist you in validating member eligibility.
4. Submission of Electronic Data Interchange (EDI) Transactions X12 5010 270 (Eligibility, Coverage or Benefit Information Inquiry) and 271 (Eligibility, Coverage or Benefit Information Response)

### MEMBER ID CARD(S)

Upon successful enrollment, each KYHC member is issued a KYHC Identification Card. The member ID Card contains enrollment and benefit coverage information such as copayment amounts and important phone numbers and the claims mailing address.

It is the responsibility of the provider to verify eligibility of all KYHC members prior to each patient visit or prior to rendering services to ensure that the member is currently enrolled in a KYHC plan. Please note that each member receives his/her own Identification Card from KYHC. While a family shares a common Subscriber ID, each covered member will have an Identification Card in his or her own name. To avoid potential problems with identity theft or fraud, KYHC recommends the provider ask the member for a separate form of identification with a picture.

An example of a KYHC member Identification Card follows:

|                                                                                                                                            |                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
|  <b>Kentucky Health Cooperative, Inc.</b>               | Card Issued: MM/DD/YYYY<br>Members and Providers Logon to:<br><a href="https://portal.mykyhc.org">https://portal.mykyhc.org</a> |
| PPO<br>Member ID: 123456789                                                                                                                | Payer ID: 77894<br>Group #: 12345                                                                                               |
| Member Name: JOHN DOE                                                                                                                      | Office Visit Copay: \$00<br>Specialist Copay: \$00<br>Urgent Care Copay: \$00<br>ER Copay: \$00                                 |
| RX BIN: 016838<br>Pharmacy Benefit: \$00/\$00/\$00/00%<br>Pharmacist Help Desk: 1-888-821-5517<br>Pharmacy Member Services: 1-888-821-5516 |                                                                                                                                 |

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## PRIMARY CARE PHYSICIANS

KYHC does NOT require each member to select a Primary Care Physician (PCP) for access to medically necessary services; and referrals are not required in order for members to see specialists. However, if they desire to do so, KYHC allows members to designate a PCP within KYHC’s participating provider network. For children, a pediatrician may be designated as a PCP.

## NEWBORNS

KYHC will provide automatic coverage for newly born children from the moment of birth for the first 31 days.

## ESSENTIAL HEALTH BENEFITS (EHB)

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance abuse disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services, and Chronic disease management
10. Pediatric services, including oral and vision care- KYHC does not provide pediatric dental services in any plan offerings. On the state health insurance marketplace, dental-only plans are available to meet this requirement. Outside of the state health insurance marketplace, KYHC obtains, via the enrollment process, “reasonable assurances” that pediatric dental services have been purchased.

## COLLECTING COPAYMENTS

When applicable, a copayment is typically collected from the member at the time of service at the servicing location. Copayments for office visits, specialist office visits, urgent care, emergency room and prescriptions are listed on the front of member’s ID Card.

## EXPLANATION OF BENEFITS (EOB)

KYHC generates an Explanation of Benefits (EOB) form after each medical service is rendered to a member; a copy of the EOB is available on the secure portal. An EOB is a summary of the coverage the member received. The EOB is not a bill but a statement. The EOB provides the member with information on whether the claim was paid or denied. If the claim was paid, KYHC shows the amount allowed to the provider under the provider's compensation arrangement, less any cost sharing responsibility (*e.g.*, copayment, deductible, coinsurance) of the member. Finally, the EOB provides the member general information about his or her appeal rights and information regarding the right to bring action after the appeals process.

## 6.0 CLAIM OR ENCOUNTER SUBMISSIONS AND EDITING

### CLAIM FILING INFORMATION

Please file claims electronically whenever possible. For questions about electronic submissions or if you want to know more about Electronic Data Interchange (EDI), please refer to the EDI Submissions sub-section or call **1-855-OUR-KYHC (1-855-6875942)**.

If filing claims on paper, failure to submit them on the most current CMS-1500 or CMS-1450 (UB-04) claim form will cause the claim to be rejected and returned.

Kentucky Health Cooperative Inc. ("KYHC") utilizes an Intelligent Character Recognition (ICR) system to capture claims information directly from the paper claim form. This provides greater efficiency; improved accuracy; and tighter controls over the data input. With the ICR system, it is important that claims be submitted with proper and legible coding.

#### **The claim form must be:**

- An original CMS-1500 for professional claims or CMS-1450 (UB-04) for facility claims printed in red "drop out" ink with the printed information on back (photocopies are not acceptable);
- If submitting a multiple page claim, the word "continued" should be noted in the total charge field, with the total charge submitted included on the last page of the claim. Do not staple over pertinent information;
- 8 1/2" x 11" with the printer pin-feed edges removed at the perforations;
- Free from crumples, tears, or excessive creases (to avoid this, submit claims in an envelope that is full letter size or larger);
- Thick enough (20-22 lbs.) to keep information on the back from showing through;
- Clean and free from stains, tear-off pad glue, notations, circles or scribbles, strike-overs, crossed-out information or white out.

Follow these tips for completing paper claims to increase first pass acceptance of through the ICR, reducing adjudication times:

#### **The font should be:**

- Legible (laser printers are recommended)
- In black ink
- Pica or Arial in 10, 11 or 12 font type and size
- CAPITAL letters

#### **The font must NOT have:**

- Broken characters
- Script, italics or stylized font
- Red ink
- Mini-font
- Dot Matrix font

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**Do NOT bill with:**

- Liquid correction fluid changes
- More than six service lines per claim (use a new claim form for additional services);
- Narrative descriptions of procedure, narrative description of modifier or narrative description of diagnosis (the CPT, Modifier and/or ICD-9/ICD-10 codes are sufficient);
- Stickers or rubber stamps (such as "tracer," "corrected billing," provider name and address, etc.);
- KYHC's address at top of the form;
- Special characters (*i.e.*, hyphens, periods, parentheses, dollar signs and ditto marks);
- Handwritten descriptions;
- Attachments smaller than 8 1/2 x 11;
- Character fonts mixed on the same form;
- Extraneous data printed, handwritten or stamped on the form;
- Handwritten corrections.

**PAPER CLAIM SUBMISSION**

KYHC utilizes the CMS-1500 (rev. 08-05) paper claim form for professional services. Failure to submit on a CMS-1500 claim form will result in the claim being returned or claim denial. KYHC requires CMS-1500 claims be submitted with a valid National Provider Identifier (NPI) as the practitioner identifier. Paper claims must be submitted with a valid NPI in the correct practitioner fields on the form. Paper claims submitted without an NPI in the correct field location, will be returned to the practitioner for correction and resubmission. It is important that practitioners submit claims to KYHC with the appropriate group or individual National Provider Identifier (NPI) for timely and accurate processing, and to avoid returned and/or denied claims.

Use the CMS-1450 (UB-04) claim form to submit paper claims for facility (technical) services. Failure to submit on a CMS-1450 (UB-04) claim form will result in the claim being returned to the facility or claim denial. KYHC requires that CMS-1450 (UB-04) paper claim forms be submitted with a valid National Provider Identifier (NPI) as the provider identifier. Paper claims must be submitted with a valid NPI in the correct provider fields on the form. Paper claims submitted without an NPI or without an NPI in the correct field location, will be returned to providers for correction and resubmission.

**ELECTRONIC DATA INTERCHANGE (EDI) SUBMISSIONS (837I AND 837P)**

KYHC accepts Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant X12 5010 837I and 837P claims transactions. KYHC has selected Optum as its gateway for EDI transactions.

Providers have two options of transmitting claims electronically through the Optum gateway:

- Through your existing EDI clearinghouse – Optum maintains relationships with many existing clearinghouses which already service Kentucky providers, including Emdeon, Payer Path, Zirmed, and McKesson. Please contact your clearinghouse in order to submit claims to KYHC.
- **KYHC payer ID is 77894.**
- Contract with a clearinghouse – KYHC does not endorse any specific clearinghouse. Providers need to evaluate clearinghouses based on their specific practice needs.
- If not utilizing electronic claim submissions, and wish to become an electronic biller, contact one of the clearinghouses listed at:
  - <https://mykyhc.org/healthproviders/Pages/default.aspx> OR
  - Visit [http://www.enshealth.com/signup\\_online/](http://www.enshealth.com/signup_online/)
  - Call Optum at **1-800-341-6141** to determine if electronic claim submission is right for your practice.

KYHC publishes addendums to full Health Insurance Portability and Accountability Act of 1996 (HIPAA) companion guides. These addendums provide the specific information needed to bill KYHC. They are not intended to replace or modify the HIPAA standard guides. These addendums are located at KYHC's Web site at:

<https://mykyhc.org/healthproviders/Pages/default.aspx>.

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## EDI EDITING

As a Council for Affordable Quality Healthcare and Council Committee on Operating Rules for Information Exchange (CAQH CORE) Phase I and II certified EDI clearinghouse, Optum edits transactions up through level 5 before passing the transaction to KYHC for policy editing. This means providers may see claims reject during the EDI submission process as a result of editing done by your contracted clearinghouse or Optum.

Information edited by the clearinghouses include:

- Type 1: EDI Syntax integrity Testing – Testing of the EDI file for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 or NCPDP syntax, and compliance with X12 or NCPDP rules. This will validate the basic syntactical integrity of the EDI submission.
- Type 2: HIPAA Syntactical Requirement Testing – Testing for HIPAA Implementation Guide-specific syntax requirements, such as limits on repeat counts, used and not used qualifiers, codes, elements and segments. Also included in this type is testing for HIPAA required or intra-segment situational data elements, testing for nonmedical code sets as laid out in the Implementation Guide, and values and codes noted in the Implementation Guide via an X12 code list or table.
- Type 3: Balancing – Testing the transaction for balanced field totals, financial balancing of claims or remittance advice, and balancing of summary fields, if appropriate. An example of this includes items such as all claim line item amounts equal the total claim amount.
- Type 4: Situation Testing – The testing of specific inter-segment situations described in the HIPAA Implementation Guides, such that: If A occurs then B must be populated. This is considered to include the validation of situational fields given values or situations present elsewhere in the file. Example: if the claim is for an accident, the accident date must be present.
- Type 5: External Code Set Testing – Testing for valid Implementation Guide-specific code set values and other code sets adopted as HIPAA standards. This level of testing will not only validate the code sets but also make sure the usage is appropriate for any particular transaction and appropriate with the coding guidelines that apply to the specific code set. Validates external code sets and tables such as CPT, ICD-9, HCPCS Level II, status codes, adjustment reason codes, and their appropriate use for the transaction.

## ENHANCED CLAIMS EDITING AND PAYMENTS

KYHC has selected Optum CES to validate that claims are adjudicated in compliance with Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI).

There are two main components of the CMS mandate:

- NCCI – procedure-to-procedure edits for practitioners, ambulatory surgical centers, and outpatient hospital services that define pairs of HCPCS/CPT codes that should not be reported together.
- Medically Unlikely Edits (MUE) – these are units-of-service edits for practitioners, ambulatory surgical centers, outpatient hospital services, and durable medical equipment. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct. (e.g., claims for excision of more than one appendix or more than one hysterectomy).

The purpose of these mandated edits is to prevent improper payments when a provider submits incorrect code combinations or to avoid payments of units in excess of what is medically unlikely.

## NCCI IMPLEMENTATION

To comply with the CMS mandate, KYHC will implement NCCI editing in phases. The first phase will edit professional services to:

- Reconcile the diagnosis code to the procedure and sex code for consistency;
- Identify unbundling of services, up coding of services, obsolete or invalid codes.

These edits will be implemented within the claims adjudication system during the 2<sup>nd</sup> Quarter 2014, but will be retroactive to claims for dates of service back to January 1, 2014. This may result in adjustments to previous provider payments. As KYHC progresses through the NCCI implementation, it will notify providers through KYHC bulletins posted at [www.mykyhc.org](http://www.mykyhc.org).

After the first phase is complete, KYHC will identify advanced clinical editing to be performed. This editing may include:

### Medical necessity edits

- No supporting diagnosis
- Not medically necessary for this age or gender
- Missing appropriate secondary diagnosis
- Missing appropriate associated procedures

### Coding issues

- Inappropriate coding of bilateral services
- Evaluation & management (E&M) with surgery without modifier 25
- Claim contains only incidental services
- Terminated procedure with units >1
- Multiple E&M services with same revenue code on same date
- Revenue center requires HCPCS
- Implantable device without surgery

### Inpatient edit examples

- Invalid diagnosis code
- Diagnosis code requires 3<sup>rd</sup> or 4th digit
- Invalid procedure code
- Secondary diagnosis duplicates the principal diagnosis
- Diagnosis/procedure conflicts with patient age or sex
- Invalid principal diagnosis
  - Manifestation
  - Non-specific
  - V-codes
  - E-code
- Invalid age, sex, discharge status

## ENHANCED CLAIMS EDITING

KYHC uses enhanced claims editing to review claims on a prepayment basis for unbundling and other inappropriate billing practices. Enhanced claims editing is executed by the use of an automated product that contains auditing logic designed to evaluate professional billing for CPT coding appropriateness and to reduced claim overpayments.

Following CPT coding guidelines will prevent claim denials due to these enhanced claim edits. Any edits rendered will be explained by a message code on the provider remittance advice.

The following edit categories outline these enhanced claims edits that are systematically executed.

- Age conflicts
- Alternate code replacements
- Assistant surgeon requirements
- Billed date(s) of service
- Cosmetic procedures
- Duplicate and bilateral procedures
- Gender conflicts
- Incidental procedure
- Modifier auditing
- Mutually exclusive procedure
- Preoperative (pre-op) and postoperative (post-op) auditing billed
- Procedure unbundling
- Unlisted procedures

The complete set of code edits is proprietary and, as such, cannot be released to the general public.

## CLAIMS FOR MUTUALLY EXCLUSIVE PROCEDURES

Mutually exclusive procedures are 2 or more procedures that are usually not performed during the same patient encounter on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedure, where the physician should be submitting only 1 procedure code. Example: procedure 58260 (vaginal hysterectomy) and procedure 58150 (total abdominal hysterectomy) are considered to be mutually exclusive.

## CLAIMS EDITING REVIEW REQUESTS

Issues appropriate for medical review include the following.

- Requests for verification that the edit was correctly applied to the claim
- Requests for an explanation of auditing logic
- Situations that you submit additional documentation substantiating that unusual circumstances existed requests for review of edits must be received within 90 days of the date of the remittance advice and are resolved within 30 days of receipt. Participating providers who are interested in a medical review should request consideration on a case-by-case basis.

Appropriate attachments with supporting documentation, a letter and copy of the claim may be submitted to:

Kentucky Health Cooperative, Inc.  
Attn: Appeals Department  
9700 Ormsby Station Road, Suite 100  
Louisville, KY 40223

## COMMON CAUSES OF CLAIM PROCESSING DELAYS, REJECTIONS OR DENIALS

- Authorization number invalid or missing
- Attending physician ID invalid or missing
- Billed charges missing or incomplete
- Diagnosis code missing 4<sup>th</sup> or 5<sup>th</sup> digit
- Diagnosis, procedure or modifier codes invalid or missing
- EOB's from primary insurers missing or incomplete
- External cause of injury codes
- Future claim dates
- Handwritten claims
- Member name missing
- Member plan identification number missing or invalid
- Newborn claim information missing or invalid
- Payer or other insurer information missing or incomplete
- Place of Service code missing or invalid
- Provider name missing
- Provider NPI missing or invalid
- Revenue codes missing or invalid
- Spanning dates of service do not match the listed days/units
- Tax Identification Number missing or invalid
- Type of bill incorrect
- Taxonomy errors

## CLAIM CORRESPONDENCE FILING INFORMATION

Mail medical paper claims or any claims-related correspondence to:

Kentucky Health Cooperative, Inc.  
P.O. Box 9107  
Foxboro, MA 02035

## COMPLETING A CMS-1500

On the following pages are instructions to assist with filling out a CMS-1500 form. For additional assistance or further information regarding KYHC claims submission guidelines or payment policies, contact KYHC's provider call center at **1-855-OUR-KYHC (1-855-687-5942)**.

| 1500                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | CARRIER |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|---------|--|
| HEALTH INSURANCE CLAIM FORM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |         |  |
| APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 05/06                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  |         |  |
| <div> <div> <div>1. MEDICARE</div> <div>2. MEDICAID</div> <div>3. TRICARE</div> <div>4. CHAMPVA</div> <div>5. GROUP HEALTH PLAN</div> <div>6. FECA</div> <div>7. OTHER</div> </div> <div> <div>8a. INSURED'S I.D. NUMBER</div> <div>8b. INSURED'S NAME (Last Name, First Name, Middle Initial)</div> <div>8c. INSURED'S ADDRESS (No., Street)</div> <div>8d. INSURED'S DATE OF BIRTH</div> <div>8e. INSURED'S SEX</div> <div>8f. EMPLOYER'S NAME OR SCHOOL NAME</div> <div>8g. INSURANCE PLAN NAME OR PROGRAM NAME</div> <div>8h. IS THERE ANOTHER HEALTH BENEFIT PLAN?</div> </div> </div> |  |  |  |  |  |  |  |  |  |         |  |
| <div> <div>9. PATIENT'S NAME (Last Name, First Name, Middle Initial)</div> <div>10. IS PATIENT'S CONDITION RELATED TO:</div> <div>11. EMPLOYMENT? (Current or Previous)</div> <div>12. AUTO ACCIDENT?</div> <div>13. OTHER ACCIDENT?</div> <div>14. RESERVED FOR LOCAL USE</div> </div>                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  |         |  |
| <div> <div>15. DATE OF CURRENT ILLNESS (First symptom or injury/accident) OR PHASE (N/A)</div> <div>16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE</div> <div>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</div> <div>18. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</div> <div>19. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</div> <div>20. OUTSIDE LAB?</div> <div>21. MEDICARE RESUBMISSION CODE</div> <div>22. PRIOR AUTHORIZATION NUMBER</div> </div>                                                                                                |  |  |  |  |  |  |  |  |  |         |  |
| <div> <div>23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by line)</div> <div>24. A. DATE(S) OF SERVICE</div> <div>24. B. PLACE OF SERVICE</div> <div>24. C. PROCEDURE, SERVICE, OR SUPPLY</div> <div>24. D. PROCEEDURES, SERVICES, OR SUPPLIES</div> <div>24. E. DIAGNOSIS</div> <div>24. F. \$ CHARGES</div> <div>24. G. DAYS OF UNIT</div> <div>24. H. ICD-9-CM</div> <div>24. I. ICD-10</div> <div>24. J. RENDERING PROVIDER ID. #</div> </div>                                                                                                    |  |  |  |  |  |  |  |  |  |         |  |
| <div> <div>25. FEDERAL TAX I.D. NUMBER</div> <div>26. PATIENT'S ACCOUNT NO.</div> <div>27. ACCEPT ASSIGNMENT?</div> <div>28. TOTAL CHARGE</div> <div>29. AMOUNT PAID</div> <div>30. BALANCE DUE</div> </div>                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |         |  |
| <div> <div>31. SIGNATURE OF PHYSICIAN OR SUPPLIER</div> <div>32. SERVICE FACILITY LOCATION INFORMATION</div> <div>33. BILLING PROVIDER INFO &amp; PH #</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |         |  |
| <div> <div>34. SIGNED</div> <div>35. DATE</div> <div>36. NPI</div> <div>37. NPI</div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |         |  |

NJCC Instruction Manual available at: [www.njcc.org](http://www.njcc.org)

OMB APPROVAL PENDING

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## CMS-1500 FIELD COMPLETION

The "Type" column indicates whether a particular block is:

**M** = Mandatory (if applicable)    **O** = Optional    **N/A** = Not Applicable

| FORM LOCATOR NUMBER | NAME                                   | TYPE | INSTRUCTIONS                                                                                                                                                                                                                                                   |
|---------------------|----------------------------------------|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1                   | Type of insurance coverage             | O    | Check appropriate box to indicate health insurance type                                                                                                                                                                                                        |
| 1a                  | Insured's ID number                    | M    | Enter the identification numbers, (Member number), as shown on the patient's ID card                                                                                                                                                                           |
| 2                   | Patient's name                         | M    | Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's ID card <ul style="list-style-type: none"> <li>• Include any titles and both names, if hyphenated</li> </ul>                                                  |
| 3                   | Patient's birth date, sex              | M    | Enter the patient's date of birth (MMDDCCYY) and sex                                                                                                                                                                                                           |
| 4                   | Insured's name                         | M    | Enter the policyholder or subscriber (used for identification purposes only, particularly when last names differ) <ul style="list-style-type: none"> <li>• When the insured and the patient name are the same, enter the word "SAME"</li> </ul>                |
| 5                   | Patient's address                      | M    | Enter the patient's permanent mailing address and telephone number <ul style="list-style-type: none"> <li>• On the first line, enter the street address; the second, the city and state; the third, the zip code and telephone number</li> </ul>               |
| 6                   | Patient's relationship to insured      | M    | Enter an X in the appropriate box for patient's relationship to the insured when item 4 is completed                                                                                                                                                           |
| 7                   | Insured's address                      | M    | Enter the insured's complete address and the telephone number, except when the address is the same as the patient's, then enter the word "SAME" <ul style="list-style-type: none"> <li>• Complete this block only when blocks 4 or 11 are completed</li> </ul> |
| 8                   | Patient's status                       | O    | Enter an X in the appropriate box for patient's marital status and for the patient's employment and student status                                                                                                                                             |
| 9                   | Other insured's name                   | O    | Enter the last name, first name, and middle initial of policyholder or subscriber if another health policy exists                                                                                                                                              |
| 9a                  | Other insured's policy or group number | O    | Enter the policy or group number of the other health insurance policy                                                                                                                                                                                          |
| 9b                  | Other insured's date of birth, sex     | O    | Enter the other insured's date of birth (MMDDCCYY) and sex                                                                                                                                                                                                     |
| 9c                  | Employer's name or school name         | O    | Enter the other insured's employer's name or school name                                                                                                                                                                                                       |

| FORM LOCATOR NUMBER | NAME                                                                                         | TYPE | INSTRUCTIONS                                                                                                                                                                                                                  |
|---------------------|----------------------------------------------------------------------------------------------|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 9d                  | Insurance plan name or program name                                                          | O    | Enter the other insured's insurance plan name or program<br>• Attach an EOB for primary insurers, if applicable                                                                                                               |
| 10a, 10b<br>10c     | Is patient's condition related to:<br>• Employment?<br>• Auto accident?<br>• Other accident? | M    | Check Yes or No to indicate whether employment, auto liability or other accident applies to one or more of the services described in block 24<br>• Enter the two-letter postal code in 10b, if applicable                     |
| 10d                 | Reserved for local use                                                                       | O    | Use this block to indicate that other insurance information is attached to the claim (i.e., other carrier's EOB)                                                                                                              |
| 11                  | Insured's policy group or FECA number                                                        | M    | Enter the insured's policy or group number (For the program listed in block 1)                                                                                                                                                |
| 11a                 | Insured's date of birth, sex                                                                 | M    | Enter the insured's date of birth (MMDDCCYY) and sex, if different from block 3                                                                                                                                               |
| 11b                 | Employer's name or school name                                                               | M    | Enter the employer's name or school name, if applicable<br>• Data in this field is used to determine if Kentucky Health CO-OP is primary or secondary payer                                                                   |
| 11c                 | Insurance plan name or program name                                                          | M    | Enter the insurance plan name or program name, if applicable, to determine if supplemental or other insurance is relevant<br>• If other insurance is Humana, Anthem, etc., provide the name of the state or geographical area |
| 11d                 | Is there another health benefit plan?                                                        | M    | Check Yes or No to indicate if there is, or is not, another primary health benefit plan<br>• For example, the patient may be covered under insurance held by a spouse, parent or other person                                 |
| 12                  | Patient's or authorized person's signature                                                   | M    | Have the patient or authorized representative sign and date this block OR indicate SIGNATURE ON FILE<br>• If the patient's representative signs, the relationship to the patient must be indicated                            |
| 13                  | Insured's or authorized person's signature                                                   | M    | The insured's or authorized person's signature in this block authorizes payment of benefits to the participating physician or supplier OR indicate SIGNATURE ON FILE                                                          |
| 14                  | Date of current illness, injury or pregnancy                                                 | M    | Enter the date of the current illness, injury or pregnancy (MMDDCCYY)                                                                                                                                                         |
| 15                  | If the patient has had the same or similar illness give first date                           | O    | If this is a recurring illness, enter date first treated (MMDDCCYY)                                                                                                                                                           |

| FORM LOCATOR NUMBER | NAME                                                | TYPE | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------|-----------------------------------------------------|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 16                  | Date patient's unable to work in current occupation | O    | If the patient is unable to work, enter to and from dates that the patient is unable to work (MMDDCCYY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 17                  | Name of referring physician or other source         | O    | Enter the full name and credentials of the referring or ordering physician, if the services or item was ordered or referred by a physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 17a                 | Other ID                                            | O    | Do not enter a Provider ID in this field                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 17b                 | National Provider Identifier (NPI)                  | O    | Enter valid NPI of the referring physician if box 17 is completed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 18                  | Hospitalization dates related to current services   | M    | Complete this block when a medical service is furnished as a result of, or subsequent to, a related hospitalization (MMDDCCYY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 19                  | Reserved for local use                              | O    | Enter the date the patient was last seen by the referring and/or ordering physician for a claim billed by an independent physical therapist, podiatrist or psychotherapist                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 20                  | Outside lab                                         | M    | Use this block to indicate that laboratory work was performed outside the physician's office <ul style="list-style-type: none"> <li>• If Yes, identify which tests were sent to the outside lab, as well as charges for those tests</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                          |
| 21                  | Diagnosis or nature of illness or injury            | M    | Enter the patient's diagnosis/condition indicated by an industry standard ICD-9 code number <ul style="list-style-type: none"> <li>• Enter up to four codes in priority order (primary, secondary condition)</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 22                  | Medicare resubmission code                          | N/A  | Not applicable to Kentucky Health Cooperative                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 23                  | Prior authorization number                          | O    | Use this block to identify Kentucky Health Cooperative pre-certification or authorization number, if/when applicable                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 24a                 | Date(s) of Service                                  | M    | Enter the month, day and year for each procedure, service <ul style="list-style-type: none"> <li>• Enter the date of service per claim line unless reporting a range of dates <ul style="list-style-type: none"> <li>• If billing a range of dates on one claim line, the dates must be consecutive. Consecutive date ranging is acceptable for the following services only: Inpatient stay management, Hemodialysis management-use monthly CPT codes(s) only, Radiation therapy management-use weekly CPT code(s) only, Hospice care, VNA/home health care (includes therapies that are part of home care only)</li> </ul> </li> </ul> |
| 24b                 | Place of service                                    | M    | Enter the appropriate CMS defined industry-standard place of service (POS) code                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

| FORM LOCATOR NUMBER | NAME                                | TYPE | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------|-------------------------------------|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 24c                 | EMG                                 | N/A  | Not applicable for Kentucky Health Cooperative                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 24d<br>24d          | Procedure, service or supplies      | M    | <p>Industry standard CPT codes are required for all professional services</p> <ul style="list-style-type: none"> <li>• Industry standard HCPCS Level II codes should be used to define pharmacy, DME, ambulance and other services specifically identified to utilize these codes</li> <li>• If provider contract specifies unique codes, Provider must bill using them</li> <li>• When applicable, enter the appropriate CPT-4/HCPCS modifiers with the CPT-4/HCPCS codes</li> <li>• Use unlisted CPT codes only when necessary. If used, clinical supporting documentation must accompany claim</li> </ul> |
| 24e                 | Diagnosis Pointer                   | M    | <p>Enter the diagnosis reference number (i.e., up to four industry standard ICD-9 codes) as shown in block 21, to relate the date of service and the procedures performed to the appropriate diagnosis</p> <ul style="list-style-type: none"> <li>• Enter a maximum of four diagnosis codes; if multiple services are being performed, enter the diagnosis codes associated with each service</li> <li>• All medical and dental/oral surgery claims must indicate a diagnosis code for proper claims adjudication</li> </ul>                                                                                 |
| 24f                 | Charge                              | M    | <p>Enter the charge for each listed service</p> <ul style="list-style-type: none"> <li>• Home infusion Providers must enter the contracted rate for each listed service</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 24g                 | Days or units or anesthesia minutes | M    | <p>Enter the days or units for multiple visits, units or supplies or anesthesia actual time (in minutes)</p> <ul style="list-style-type: none"> <li>• Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple urinary supplies or allergy testing procedures). When multiple services are provided, enter the actual number</li> </ul>                                                                                                                                                                                                        |
| 24h                 | EPSDT                               | N/A  | Not applicable to Kentucky Health Cooperative                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 24i                 | ID Qualifier                        | O    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 24j                 | Rendering Provider NPI              | M    | Enter valid NPI of the rendering Provider on every service line billed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 25                  | Federal tax ID number               | M    | Enter your physician/supplier federal tax ID (employer identification number-EIN) or Social Security Number (SSN)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 26                  | Patient's account number            | O    | <p>Enter the patient's account number assigned by the physician's/supplier's accounting system</p> <ul style="list-style-type: none"> <li>• Information entered in this block will appear on your Explanation of Payment</li> </ul>                                                                                                                                                                                                                                                                                                                                                                          |

| FORM LOCATOR NUMBER | NAME                                                                | TYPE | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------|---------------------------------------------------------------------|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 27                  | Accept assignment                                                   | M    | Use this block to indicated whether or not the physician accepts assignment for the claim <ul style="list-style-type: none"> <li>By accepting assignment, the physician agrees to accept the amount paid by the third party as payment in full for the encounter</li> </ul>                                                                                                                                                         |
| 28                  | Total charge                                                        | M    | Enter the total charges for the services (i.e., total of all charges in block 24f)                                                                                                                                                                                                                                                                                                                                                  |
| 29                  | Amount paid                                                         | O    | Record the amount paid by the other carrier in this block and attach the Explanation of Payment <ul style="list-style-type: none"> <li>This block is applicable only when payment has been received from another insurance carrier prior to claim submission to Kentucky Health Cooperative</li> <li>Do not use this block to indicate what the Member has paid you for copayments, coinsurance, etc.</li> </ul>                    |
| 30                  | Balance due                                                         | M    | Enter the balance due (block 28 minus block 29)                                                                                                                                                                                                                                                                                                                                                                                     |
| 31                  | Signature of physician or supplier including degrees or credentials | M    | Affix the signature and name of the supervising or directing physician/supplier and the date the form was signed                                                                                                                                                                                                                                                                                                                    |
| 32                  | Name and address of Facility where services were rendered           | M    | If services were rendered in a hospital, clinic, laboratory or any Facility other than the patient's home or physician's office, enter the name and address of the person or organization performing the services <ul style="list-style-type: none"> <li>List the physician's practice address here, if different from block 33 If this claim is for ambulance service, please indicate the pick-up address in this box.</li> </ul> |
| 32a                 | Service Facility NPI                                                | O    | Enter valid NPI of the Servicing Facility                                                                                                                                                                                                                                                                                                                                                                                           |
| 32b                 | Other ID                                                            | O    |                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 33                  | Physician's, supplier's, billing name, address, zip code & phone #  | M    | Enter the payee's name, address and telephone number (i.e., the physician, hospital, medical/billing group) <ul style="list-style-type: none"> <li>This address is used by Kentucky Health Cooperative to return any rejected claims</li> </ul>                                                                                                                                                                                     |
| 33a                 | Billing Provider NPI                                                | M    | Enter valid NPI of the Billing Provider                                                                                                                                                                                                                                                                                                                                                                                             |
| 33b                 | Other ID                                                            | O    |                                                                                                                                                                                                                                                                                                                                                                                                                                     |

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Additional information about Kentucky Health Cooperative, Inc. is available at [www.mykyhc.org](http://www.mykyhc.org).  
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On the following pages are instructions to assist with filling out a CMS-1450 (UB-04) form. For additional assistance or further information regarding KYHC's claims submission guidelines or payment policies, contact KYHC's provider call center at **1-855-OUR-KYHC (1-855-687-5942)**.

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## CMS-1450 (UB-04) FIELD COMPLETION

The "Type" column indicates whether a particular block is:

**M** = Mandatory (if applicable)    **O** = Optional    **N/A** = Not Applicable

| FORM LOCATOR NUMBER | NAME                                      | TYPE | INSTRUCTIONS                                                                                                                                                                                                                                                                     |
|---------------------|-------------------------------------------|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1                   | Untitled (identified by a large number 1) | M    | Enter servicing Provider name, address, city, state and zip code <ul style="list-style-type: none"> <li>P. O. box may be included</li> <li>Phone and fax numbers desirable</li> <li>This address is used by Kentucky Health Cooperative to return any rejected claims</li> </ul> |
| 2                   | Pay to name and address                   | N/A  | Pay to name and address if the "Pay To" is different from what is in FL01                                                                                                                                                                                                        |
| 3a-b                | Patient control number                    | M    | <ul style="list-style-type: none"> <li>Line a-Enter patient account number</li> <li>Line b-Enter medical record number</li> </ul>                                                                                                                                                |
| 4                   | Type of bill                              | M    | Enter three-digit alphanumeric code to indicate type of bill being submitted                                                                                                                                                                                                     |
| 5                   | Fed. tax number                           | M    | Enter hospital/Provider federal tax identification number Federal tax identification numbers must be entered on all claims                                                                                                                                                       |
| 6                   | Statement covers period-<br>From/ through | M    | Enter beginning (from) and ending (through) dates for period covered by this bill (MMDDCCYY) <ul style="list-style-type: none"> <li>For inpatient and outpatient claims that span dates</li> </ul>                                                                               |
| 7                   | Untitled                                  | N/A  |                                                                                                                                                                                                                                                                                  |
| 8a-b                | Patient ID Patient name                   | M    | <ul style="list-style-type: none"> <li>Line a-Enter patient ID number</li> <li>Line b-Enter patient's last name, first name, and middle initial (if any) For example: Doe, John Q.</li> </ul>                                                                                    |
| 9a-e                | Patient address                           | M    | Enter patient's full mailing address, including street number and name, P.O. box or RFD, city, state and zip code                                                                                                                                                                |
| 10                  | Birth date                                | M    | Enter patient's date of birth (MMDDCCYY)                                                                                                                                                                                                                                         |
| 11                  | Sex                                       | M    | Enter M (male) or F (female)                                                                                                                                                                                                                                                     |
| 12                  | Admission date                            | M    | Enter month, day and year of admission (MMDDCCYY)                                                                                                                                                                                                                                |
| 13                  | Admission Hour                            | O    |                                                                                                                                                                                                                                                                                  |
| 14                  | Admission type                            | M    | Enter the appropriate source of admission code <ul style="list-style-type: none"> <li>Required for inpatient only</li> </ul>                                                                                                                                                     |
| 15                  | Admission SRC (Source of admission)       | M    | Enter the time the patient was discharged <ul style="list-style-type: none"> <li>Required for inpatient only</li> </ul>                                                                                                                                                          |

| FORM LOCATOR NUMBER | NAME                                   | TYPE | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------|----------------------------------------|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 16                  | DHR (Discharge Hour)                   | M    | Enter the time the patient was discharged<br>• Required for inpatient only                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 17                  | Stat (Patient discharge status)        | M    | Indicates the patient status as of the through date of the billing period<br>• Required for inpatient medical, SNF, hospice, and outpatient hospital services                                                                                                                                                                                                                                                                                                                                                                                      |
| 18-28               | Condition codes                        | O    | Enter the appropriate two-digit codes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 29                  | Accident state                         | M    | Enter state in which accident occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 30                  | Untitled                               | N/A  | Not applicable                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 31-34               | Occurrence codes and dates             | O    | Enter code(s) and associated date(s) defining specific event(s) related to billing period<br>• Event codes are two alphanumeric digits<br>• Dates are shown as eight numeric digits (MMDDCCYY)<br>• Kentucky Health Cooperative requires all accident-related occurrence codes to be reported, especially when related to motor vehicle accidents                                                                                                                                                                                                  |
| 35-36               | Occurrence span                        | O    | Enter code(s) and associated beginning (from) and ending (through) date(s) defining a specific event related the billing period                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 37                  | Untitled                               | N/A  | Not applicable                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 38                  | Responsible party/name and address     | M    | Enter name and address of person who is responsible for payment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 39-41               | Value codes and amounts                | M    | Enter the appropriate code(s) Enter code(s) and related dollar amount(s)<br>• If Kentucky Health Cooperative is secondary payer to Medicare, enter value code 88z and the Medicare-approved amount in Form Locator 39A<br>• Enter any other appropriate value codes and matching dollar amounts for deductible and co-insurance in Form Locator 39B and 39C<br>• If billing for a private room, the MCSP (most common semi private) room rate, must be submitted. Failure to submit with the MCSP room rate will result in the claim being denied. |
| 42                  | Rev Code (revenue code)                | M    | Enter current industry standard three-digit uniform billing revenue code(s) to describe each type of accommodation and ancillary service billed<br>• Kentucky Health Cooperative accepts Medicare revenue codes<br>• A maximum of 19 services may be billed on one claim form, with total charges entered on the 20th line                                                                                                                                                                                                                         |
| 43                  | Description (revenue code description) | M    | Enter the narrative description or a standard abbreviation for each revenue code in Form Locator 42<br>• Show narrative on adjacent line using HCPCS/CPT-4 when possible<br>• Revenue code descriptions must match revenue code in Form- Locator 42                                                                                                                                                                                                                                                                                                |

| FORM LOCATOR NUMBER | NAME                               | TYPE | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------|------------------------------------|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 44                  | HCPCS rates/HCPCS Code             | M    | When coding HCPCS (i.e., outpatient surgery, outpatient or non-patient clinical diagnostic lab, radiology, and other diagnostic services), enter the current industry standard HCPCS/CPT-4 procedure code(s) <ul style="list-style-type: none"> <li>If code is unlisted, supporting documentation/itemization will expedite claim processing</li> <li>Enter HCPCS or CPT-4 depending on contractual agreement</li> </ul>                                                                                                                                                                                            |
| 45                  | Serv date (service date)           | M    | Enter the date of service using MMDDCCYY <ul style="list-style-type: none"> <li>For outpatient claims, report a separate date for each day of service</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 46                  | Serv. units (units of service)     | M    | Enter number of units of service by day, visit, hour or minutes as applicable for each service rendered on each reported line <ul style="list-style-type: none"> <li>Inpatient services-enter number of days</li> <li>Ancillary services-enter number of units, when applicable</li> <li>Outpatient services-enter number of units when HCPCS are used</li> </ul>                                                                                                                                                                                                                                                   |
| 47                  | Total charges                      | M    | Enter the charge amount for each line item reported                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 48                  | Non-covered charges                | M    | Enter any non-covered charges for the primary payer pertaining to the related revenue code in Form Locator 42                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 49                  | Untitled                           | N/A  | Not applicable                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 50a-c               | Payer name (payer identification)  | M    | List all health insurance carriers on file <ul style="list-style-type: none"> <li>Line a-enter the name of the primary insurance carrier</li> <li>Line b-enter the name of the secondary insurance carrier <ul style="list-style-type: none"> <li>Line c-enter the name of any other insurance carrier If applicable, attach EOB from other carrier</li> </ul> </li> </ul>                                                                                                                                                                                                                                          |
| 51                  | Health plan ID                     | M    | List Provider number assigned by health insurance carrier <ul style="list-style-type: none"> <li>Line a-enter Health Plan identification number assigned by primary insurance carrier. Enter the unique Kentucky Health Cooperative Health Plan identification number, if Kentucky Health Cooperative is primary</li> <li>Line b-enter Health Plan identification number assigned by secondary insurance carrier <ul style="list-style-type: none"> <li>Line c-enter Health Plan identification number assigned by any other insurance carrier. Do not enter federal tax identification here</li> </ul> </li> </ul> |
| 52a-c               | Rel. Info (release of information) | M    | Enter yes or no for each insurance carrier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 53a-c               | Asg ben (assignment of benefits)   | M    | For each insurance carrier, enter: <ul style="list-style-type: none"> <li>Y if assignment of benefits is on file</li> <li>N if no assignment of benefits is on file</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 54a-c               | Prior payments (payer and patient) | M    | Report all prior payment for the claim. Attach EOB from other carrier when applicable                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

| FORM LOCATOR NUMBER | NAME                                                                                                              | TYPE | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------|-------------------------------------------------------------------------------------------------------------------|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 55                  | Est. amount due (estimated amount due)                                                                            | O    | Not applicable                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 56                  | National Provider Identifier (NPI)                                                                                | M    | Enter valid NPI of the servicing Provider-if you are an Atypical Service Provider, this field should be left blank.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 57a-c               | Other Prv ID (other Provider ID) <ul style="list-style-type: none"> <li>• Primary</li> <li>• Secondary</li> </ul> | O    | Other Prv ID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 58a-c               | Insured's name                                                                                                    | M    | Enter the name of the policyholder that is the subscriber/ insured for each insurance indicated in Form Locator 50 a-c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 59                  | P. rel. (Patient's relationship to insured)                                                                       | M    | Enter the code to indicate the relationship of the patient to the identified insured/subscriber <ul style="list-style-type: none"> <li>• 00 = insured</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 60a-c               | Cert.-SSN-HIC-ID no. (Certificate Social Security Number Health Insurance Claim Identification Number)            | M    | <ul style="list-style-type: none"> <li>• Line a-enter the primary insurer's patient identification number. If Kentucky Health Cooperative, enter the identification number as shown on the patient's Membership identification card</li> <li>• Line b-enter the secondary insurer's patient identification number</li> <li>• Line c-enter any other insurer's patient identification number</li> </ul>                                                                                                                                                                                                                                            |
| 61a-c               | Group name                                                                                                        | M    | Enter name of group or plan through which the patient has insurance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 62a-c               | Insurance group no.                                                                                               | M    | Enter the identification number, control number or code assigned by the carrier or administrator to identify the group through which the patient is covered                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 63a-c               | Treatment authorization codes                                                                                     | O    | Enter Kentucky Health Cooperative authorization number for services or treatment, if applicable                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 64a-c               | Document control number                                                                                           | N/A  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 65a-c               | Employer name                                                                                                     | M    | Enter the name of the employer of the insured identified in Form Locator 58                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 66                  | DX version qualifier                                                                                              | N/A  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 67a-q               | Prin diag cd (principle diagnosis code)                                                                           | M    | Enter the primary diagnosis code <ul style="list-style-type: none"> <li>• Use industry standard ICD-9-CM coding protocols to sequence diagnoses shown to be chiefly responsible for the admission or the outpatient services</li> <li>• Code must be to the 4th or 5th digit specification, if applicable</li> <li>• If the diagnosis is accident related, an occurrence code accident date is required. <ul style="list-style-type: none"> <li>• For acute inpatient hospital claims, appropriate ICD-9 CM code and present on admission (POA) indicator, are required on claims submitted to Kentucky Health Cooperative</li> </ul> </li> </ul> |

| FORM LOCATOR NUMBER | NAME                                           | TYPE | INSTRUCTIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------|------------------------------------------------|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 68                  | Other diag. codes (other diagnosis codes)      | M    | Enter the industry standard ICD-9-CM for up to eight secondary additional diagnoses if they co-existed at the time of the admission or developed subsequently <ul style="list-style-type: none"> <li>The codes must be to the 4th or the fifth digit specification, if applicable</li> <li>If more than one diagnosis applies to a patient, it must be listed</li> </ul>                                                                                     |
| 69                  | Adm. diag. cd. (admitting diagnosis code)      | M    | Enter the industry standard ICD-9-CM diagnosis code provided by the physician at the time of admission                                                                                                                                                                                                                                                                                                                                                       |
| 70a-c               | Patient reason DX                              | O    | Optional                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 71                  | PPS Code (Prospective Payment System) Optional | O    | Optional                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 72                  | ECI (external cause of injury code)            | M    | Enter the ICD-9-CM code for the external cause of an injury, poisoning or adverse effect <ul style="list-style-type: none"> <li>The E-code range E930-E049 (drugs, medicinal and biological substances causing adverse effects in therapeutic use) is required, when applicable</li> <li>This is mandatory information for all motor vehicle accidents</li> </ul>                                                                                            |
| 73                  | Untitled                                       | N/A  | Not applicable                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 74a-e               | Principal procedure (code and date)            | M    | Enter the industry standard ICD-9-CM code to the fourth digit specification, if applicable, to describe the principal procedure performed for the service billed <ul style="list-style-type: none"> <li>Required for all inpatient and outpatient surgeries</li> <li>Enter the date (MMDDCCYY) of the procedure</li> </ul>                                                                                                                                   |
| 75                  | No value                                       | N/A  | Not applicable                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 76                  | Attending physician                            | M    | Enter the ordering physicians National Provider Identifier, physician's last name, first name and middle initial <ul style="list-style-type: none"> <li>In the absence of an ordering physician, enter the name of the attending physician and his/her National Provider Identifier</li> </ul>                                                                                                                                                               |
| 77                  | Operating physician                            | M    | Enter the name and National Provider Identifier of the physician who performed principal procedure <ul style="list-style-type: none"> <li>If there is no principal procedure, enter the name and National Provider Identifier of the physician who performed the surgical procedure most closely related to the diagnosis</li> <li>If no procedure performed, leave blank</li> <li>Per CMS, if a procedure is performed, this is a required field</li> </ul> |
| 78-79               | Other Provider types                           | M    | Enter the name and National Provider Identifier of the physician who performed principal procedure <ul style="list-style-type: none"> <li>If there is no principal procedure, enter the name and National Provider Identifier of the physician who performed the surgical procedure most closely related to the diagnosis</li> <li>If no procedure performed, leave blank</li> <li>Per CMS, if a procedure is performed, this is a required field</li> </ul> |

| FORM LOCATOR NUMBER | NAME    | TYPE | INSTRUCTIONS                                         |
|---------------------|---------|------|------------------------------------------------------|
| 80                  | Remarks | O    | Enter any additional information pertaining to claim |
| 81a-d               | ICC     | O    | Optional                                             |

## CLAIMS PAYMENT INQUIRIES OR APPEALS

If a provider believes an error has been made during claims adjudication, the provider should first contact KYHC's provider call center at 1-855-OUR-KYHC (**1-855-687-5942**). A call center agent will review the claims adjudication and the edits applied to the claims. If, after reviewing the claim with a call center agent, the provider believes an error has been made, the provider may appeal the claim's adjudication in writing.

Providers should submit in writing the following information:

- Patient name
- Patient date of birth
- Subscriber name
- Subscriber number
- Date of service
- Justification for appeal

Providers should submit this information on their letterhead stationary, signed by an authorized representative of the provider's staff. Mail a copy of the appeal request and all associated documentation, including copies of remittance advices to:

Kentucky Health Cooperative Provider Appeals  
PO BOX 9107  
Foxboro, MA 02035

The provider will receive written disposition of their appeal within 30 business days.

## CLEAN CLAIM REQUIREMENTS AND PAYMENTS CLEAN CLAIM DEFINITION

A clean claim has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment. A provider submits a clean claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements, or revisions to data elements, attachments and additional elements, of which the provider has knowledge. Claims for inpatient and facility programs and services are to be submitted on the CMS-1450 (UB-04) and claims for individual professional procedures and services are to be submitted on the CMS-1500. In addition, claims may be submitted electronically through a contracted clearinghouse or on KYHC's Web-based claims submission application.

## CLEAN CLAIM REQUIREMENTS

The required elements of a clean claim must be complete, legible and accurate. The required claim elements are identified as mandatory in the tables above. Best efforts must be made to submit claims to KYHC within 120 days of the date of service or the date of discharge from the health Facility. Claims submitted more than a year after the date of service or date of discharge may not be paid.

A clean claim is paid within 30 days after receipt of the claim by KYHC. The 30-day time period is calculated from the date of receipt of the clean claim from the provider. If KYHC determines that one (1) or more services listed on a claim are payable, KYHC will pay for those services and won't deny the entire claim because one (1) or more other services listed on the claim are denied for payment.

## NON-CLEAN CLAIMS

A non-clean claim or "*unclean claim*" is defined as an incomplete claim, a claim that is missing any of the above information, or a claim that has been suspended in order to get more information from the provider. If you submit incomplete or inaccurate information, KYHC may reject the claim, delay processing or make a payment determination (e.g., denial, reduced payment) that may be adjusted later when complete information is obtained. KYHC applies appropriate state and federal guidelines to determine whether a claim is clean.

## CLAIM STATUS

Providers will be able to verify the status of a claim using one of four (4) methods.

1. Secure Web Portal – Kentucky Health Cooperative offers a secure Web portal for providers to utilize to verify claim status. **Providers may access the portal at <https://portal.mykyhc.org>.** Providers must enter the exact name on file with KYHC, a PIN assigned by KYHC, the provider's NPI, and the provider's Tax ID to register for the portal. If you have you not received this information, please call KYHC's provider call center at **1-855-OUR-KYHC (1-855-687-5942)** and a call center agent will assist you.
2. Interactive Voice Response (IVR) – please call **1-855-OUR-KYHC (1-855-687-5942)** and follow the prompts to verify a claim's status
3. Provider Call Center – please call KYHC's provider call center at **1-855-OUR-KYHC (1-855-687-5942)** and a call center agent will assist you in verification of claims status
4. KYHC will support Electronic Data Interchange (EDI) transactions X12 5010 276 (Health Care Claim Status Request), 277 (Health Care Claim Status Response) and 277CA (Health Care Claim Acknowledgement) in the near future. KYHC will communicate with providers as this functionality is achieved.

## ELECTRONIC REMITTANCE ADVICES (ERA)

KYHC generates Electronic Remittance Advices (ERA) in the HIPAA compliant X12 5010 835 format. An ERA allows you to systematically load payment data from KYHC into your accounting systems.

KYHC will not automatically send the ERA to providers that submit EDI claims. Providers must separately register to receive an 835. Please have your clearinghouse complete the form located at [http://www.enshealth.com/signup\\_online/](http://www.enshealth.com/signup_online/) or <https://mykyhc.org/healthproviders/Pages/default.aspx> to initiate the process for electronic remittance advices.

Paper Evidence of Payment (EOP) – As part of each payment cycle, KYHC generates an Explanation of Payment, sometimes referred to as a Remittance Advice (RA), for providers whose claims were paid or denied in that payment cycle. Explanations of Payment identify which claims were processed, the amount allowed for a service under the plan, the amount paid to the provider, and any cost sharing responsibility of the patient or member. The EOP also identifies why services may have been denied for payment, or if additional information is required from the provider in order to consider the claim for payment. It is important to carefully review the EOP to determine appropriate accounting of payments. As noted above, providers may request an ERA through their clearinghouse.

## ELECTRONIC FUNDS TRANSFER (EFT) PAYMENTS

KYHC providers are encouraged to take advantage of Electronic Funds Transfer for payments by KYHC. Providers should complete the form located at <https://mykyhc.org/healthproviders/Pages/default.aspx> to initiate the process for Electronic Funds Transfer (EFT). Please note that a copy of a voided check or a deposit slip must accompany the EFT request. It takes approximately 2-3 weeks from the date requested for EFT to take effect. Providers will continue to receive paper checks until their EFT is active. Changes in banking information and EFT termination requests are supported through the same form.

Once EFT is active, providers will have funds directly deposited into the designated account after the claims adjudication cycle. The Remittance Advice which details the business accounts and claims associated with the EFT will be generated separately. Paper Remittance Advices/Explanations of Payment are mailed to the provider's billing address. Electronic Remittance Advices are sent through the provider's designated clearinghouse.

If providers notice any discrepancy in the EFT amount or deposit process, please notify KYHC's provider call center at **1-855-OUR-KYHC (1-855-687-5942)**.

## 7.0 REIMBURSEMENT POLICIES AND PROCEDURES

### CODING AND CODE SET(S) REQUIREMENTS

Practitioners and facilities will submit claims in a format consistent with industry standards and acceptable to Kentucky Health Cooperative, Inc. (“KYHC”). Per KYHC policy and the contractual agreement, providers will follow industry standards related to billing. Examples of general industry standards include but are not limited to HCPCS, ICD-9-CM, ICD-10-CM, Revenue, Diagnosis Related Groups, health service definition manual, or subsequent forms and CPT methodology.

### EMERGENCY ROOM

The emergency room level reimbursement includes all monitoring, equipment, supply, time and staff charges. Reimbursement for the use of the emergency room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.

### COORDINATION OF BENEFITS (COB)/SUBROGATION

Participating providers shall establish procedures for identifying members who have work-related injuries or illnesses or who have other coverage (including auto insurance), that may be coordinated with KYHC coverage. Providers shall use their best efforts to notify KYHC whenever they have reason to believe a member may be entitled to coverage under any other insurance plan, including Medicare, and shall assist KYHC in obtaining Coordination of Benefits (COB) information when a member holds such other coverage.

Participating providers agree to make their best effort to identify and notify KYHC of any facts that may be related to auto, workers’ compensation, or third-party injury or illness, and to execute and provide documents that may reasonably be required or appropriate for the purpose of pursuing reimbursement or payment from other payers.

This section shall not be construed to require participating providers to waive cost shares in violation of any Medicare rule or regulation, nor shall this provision be construed to supersede any other Medicare rule or regulation.

KYHC adjudicates COB claims according to the following guidelines:

- When KYHC is the primary carrier, standard KYHC reimbursement, along with applicable copayments, coinsurance and deductibles, is considered payment in full from KYHC.
- If Medicare is the primary payer, and member has full basic secondary coverage through KYHC, then KYHC will use the Medicare allowed amount or the limiting amount (if the provider didn’t accept Medicare assignment) to determine a secondary payment.
- When KYHC is the secondary carrier and the primary carrier isn’t Medicare, the primary carrier’s allowance will be used to determine a secondary payment.
- At no time will KYHC pay more as the secondary carrier than it would have paid had it been the primary carrier.

## COB RULES

KYHC determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent: The benefits of this KYHC Plan which covers the person as an employee or Subscriber (that is, other than as a dependent) are determined before those of this KYHC Plan which covers the person as a dependent.
2. Dependent Child/Parents not Separated or Divorced: Except as stated in paragraph 3, below, when this KYHC Plan and another plan cover the same child as a dependent of different parents who are not separated or divorced:
  - a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year;
    - i. If the parents are married;
    - ii. The parents are not separated (whether or not they ever have been married); or
    - iii. A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage; but
  - b. If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
3. Dependent Child/Separated or Divorced Parents: If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - a. First, the plan of the parent with custody of the child;
  - b. Then, the plan of the spouse of the parent with custody of the child;
  - c. Then, the plan of the parent not having custody of the child; and
  - d. Finally, the plan of the spouse of the non-custodial parent.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the plan has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the secondary plan. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This sub-clause does not apply to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has actual knowledge.

4. Joint Custody: If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the Order of Benefit Determination Rules outlined above.
5. Active/Inactive Subscriber: The benefits of a plan which covers a person as an employee who is neither laid off nor retired or as that employee's Dependent are determined before those of a plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not supersede the Non-Dependent/Dependent rule above.
6. Continuation Coverage: If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
  - a. First, the benefits of a plan covering the person as an employee, Subscriber or Subscriber of as that person's dependent;
  - b. Second, the benefits under the continuation coverage. If the other plan does not have the rule described above and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

**Longer/Shorter Length of Coverage:** If none of the above rules determines the order of benefits, the benefits of the plan which covered the person longer are determined before those of the plan which covered that person for the shorter term. If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

## 8.0 CARVE-OUT DELEGATED SERVICES

### PHARMACY BENEFITS MANAGEMENT PROGRAM

The Kentucky Health Cooperative Inc. (“KYHC”) Prescription Drug Program is managed internally by KYHC Pharmacy Department staff. The purpose of the program is to provide access to therapeutically effective and safe medications for the treatment of disease and preservation of health.

### FOUR-TIER PHARMACY PRESCRIPTION DRUG BENEFIT

KYHC offers a four-tier pharmacy benefit. KYHC uses a closed formulary, KYHC provides coverage for a wide range of medications. There is a process to obtain coverage for medications not on the formulary.

Medications are categorized into one of four (4) tiers. Copayments/Coinsurances are determined by the tier to which the drug is assigned, for up to a 30-day supply per prescription or refill. KYHC encourages patients and physicians to discuss pharmaceutical treatment options.

**Tier 1** is made up of lower-cost generic drugs. These drugs contain the same active ingredients as their brand-name counterparts. Members pay the lowest copayments for Tier 1 drugs.

**Tier 2** is primarily made up of higher-cost generic drugs and will also include lower-cost brand-name drugs.

**Tier 3** is primarily made up of brand-name drugs for which generic equivalents are not available. Tier 3 will also include newer, high cost generic drugs.

**Tier 4** is made up of drugs not included in Tiers 1- 3, mainly high cost specialty and/or injectable medications.

A current Drug Tier List is available to print at any time at the KYHC Pharmacy Benefit Manager’s Web site, [www.ProCarerx.com](http://www.ProCarerx.com). For copies, **contact ProCare at 1-888-821-5517**.

### PRIOR AUTHORIZATION DRUGS

A limited number of medications require prior authorization<sup>1</sup>. Each of these medications has clinical guidelines developed by licensed clinical professionals, reflecting the latest in evidence-based medicine. The guidelines are used as a tool to promote quality, safety, and cost-effective pharmacotherapy. Providers may obtain the current list by using the website or phone numbers shown above.

<sup>1</sup>This list is subject to change.

### EXCLUDED MEDICATIONS

KYHC offers a closed formulary, providing coverage for a wide range of FDA-approved prescription medications, except those primarily used for cosmetic purposes or to treat weight loss. Compounded medications are not covered. Providers may obtain the current list of excluded drugs<sup>1</sup> by using the website or phone numbers shown above.

## QUANTITY LIMITATIONS

Quantity limits are designed to limit the use of selected drugs for quality and safety reasons. The quantity limit for each drug is supported by drug studies and by actively practicing doctors. KYHC manages a limited number of medications by limiting the quantity a member can receive either during a specified time period (e.g., 30 tablets per 30 days, or per copayment (e.g., 12 units per copayment). Administering quantity limits encourages appropriate drug use to assist in reducing drug benefit costs for everyone. To obtain the list of drugs with quantity limitations<sup>1</sup>, providers can use the Web site or phone numbers shown above.

<sup>1</sup>This list is subject to change.

If a member's physician determines that a quantity in excess of that which is allowed by the health plan is medically necessary, he/she may request an exception by submitting supporting clinical documentation for review. KYHC will review the documentation and make a determination.

## SPECIALTY PHARMACY PROGRAM

KYHC takes a very aggressive approach to controlling pharmacy costs. One strategy is the Specialty Pharmacy Program for high-cost specialty drugs. KYHC has partnered with ProCare's Specialty Pharmacy (SpecialtyCare) to dispense designated Specialty medications.

Our goal is to maximize member and provider satisfaction by offering patient education and disease management, personalized care, service excellence, 24/7 pharmacist and nurse counseling, careful inventory control, compliance management and convenient overnight delivery. Included in the program is a select list of specialty medications used to treat certain conditions including, but not limited to, multiple sclerosis, hepatitis C, Crohn's disease, and rheumatoid arthritis.

ProCare SpecialtyCare is the selected provider of these specialty pharmacy medications. SpecialtyCare will deliver directly to either the member's home or the physician's office. Providers do not have to pre-stock or purchase medications used to treat their KYHC members.

Providers may obtain the current list of drugs included in the Specialty Pharmacy Program<sup>1</sup> by:

- Accessing the Website, [www.ProCarerx.com](http://www.ProCarerx.com)
- Calling ProCare at: **1-888-821-5517**

## INFERTILITY PHARMACY PROGRAM

KYHC does not offer coverage for infertility treatment.

## MAIL-ORDER OPTION

KYHC offers our members the convenience and cost savings of a mail service prescription drug program for maintenance prescription medications used for ongoing conditions. Members can order up to a 90-day supply of these drugs, without going to the pharmacy, and save up to one-third on copayments.

Tier 1, Tier 2 and Tier 3 drugs are eligible for a copayment discount, Tier 1 medications filled for 90-day supplies will be billed at 3 months of medications for 2 copayments, Tier 2 and Tier 3 medications filled for 90-days will be billed at the rate of 3 months of medications for 2.5 copayments. Tier 4 drugs are available by mail for 30-day fills only, there is no copayment/coinsurance discount for Tier 4 medications. A detailed list is available at [www.ProCarerx.com](http://www.ProCarerx.com).

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KYHC's Mail Service Program is administered exclusively by ProCare "PharmacyCare" Mail Service. ProCare "PharmacyCare" Mail Service operates a state-of-the-art mail order Facility. Members can receive 90-day supplies of medications through their local contracted pharmacy at the same copay rate offered through mail order.

## MENTAL HEALTH AND SUBSTANCE ABUSE (MHSA) SERVICES

KYHC has contracted with MHNet for Mental Health and Substance Abuse Services. For MHNet Provider services, prior authorizations and claims management, contact MHNet at: **1-855-309-2422**. For additional information, refer to [www.mhnet.com](http://www.mhnet.com).

## PEDIATRIC VISION SERVICES

KYHC has contracted with Avēsis for Pediatric Vision Benefit Services. For Provider services, claims inquiry, etc., please contact Avēsis at: **1-866-524-8544**.

Provider Service Representatives are available for assistance from 7 a.m. to 4 p.m. Eastern Time, Monday through Friday. You may also visit the Avēsis website at [www.avēsis.com](http://www.avēsis.com) for additional information.

## 9.0 CLINICAL CARE INTEGRATION (CCI)

### NOTIFICATION

It is the responsibility of the member to notify Kentucky Health Cooperative, Inc. (“KYHC”) in a timely manner, of any proposed non-emergency treatment for which the member will be seeking benefit coverage that is on KYHC’s list of services requiring Authorization.

KYHC will allow practitioners, facilities or member representatives to assist in fulfilling that responsibility. KYHC makes all reasonable efforts to obtain the information necessary to make utilization management decisions but the responsibility for supplying such information rests with the member. If the member, practitioner, facility, or member representative does not provide the information required for review, KYHC makes its decision on the information available.

There are several types of review that KYHC performs as a part of our utilization management program. KYHC will perform pre-service review (prior authorization), concurrent review (generally for facility stays), and post service review (retrospective review). Some services require pre-service review from KYHC in order for reimbursement to be issued to the provider. Not all services require authorization.

The following services *do not* require authorization:

- Emergency services
- Well woman visits
- Family planning services – INFERTILITY IS NOT COVERED
- Basic prenatal care in-network
- Sexually transmitted disease services
- HIV testing and counseling
- Office visits to primary care practitioners
- Referrals to in-network specialists

To verify whether an authorization is necessary or to obtain a prior authorization, call or go to KYHC’s Web site at [www.mykyhc.org](http://www.mykyhc.org) to review the most current version of the authorization list.

Authorization requests may be submitted by fax, phone or secure Web portal. Authorization determinations may be communicated to the provider by 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 KYHC case manager for the completion of medical necessity screening. For all services on the prior authorization list, documentation supporting medical necessity will be required.

KYHC 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), KYHC 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 KYHC care manager or plan representative will notify the caller of the specific information needed to complete the authorization process.

## PRIOR AUTHORIZATION SERVICES

Prior authorizations are determinations about coverage for care or service that KYHC must approve, in whole or in part, in advance of a member obtaining the care or service. There are two types of prior authorization requests: standard and urgent.

Requests are expedited when they are received for urgent care. Acute inpatient care and outpatient care are considered to represent urgent care. KYHC staff (care managers and physician reviewers) may determine on a case-by-case basis which other cases represent urgent care. Members, practitioners and member representatives may request expedited prior authorization decisions; however, KYHC is not obligated to treat each request for an expedited decision as urgent. If KYHC receives a request for an expedited decision that does not appear to represent urgent care, the request will be referred to a physician reviewer for determination of whether or not the review should be expedited. If the case is determined as non-urgent, KYHC will inform the requestor that standard time frames will apply to the request along with the reason for the decision.

Clinical Information needed for prior authorization includes at least: the presenting problems, clinical exam findings, and diagnostic testing results (as appropriate). Additional information may be needed to make an authorization determination.

Authorization may be **denied** for any of the following reasons:

- The case does not meet medical necessity
- There is insufficient information to authorize the requested service
- A benefit limit or exclusionary criterion has been met

## UTILIZATION MANAGEMENT (UM) PROGRAM

KYHC's Utilization Management Program facilitates the provision of appropriate medical and behavioral health care and services to KYHC members and seeks to improve the quality of care provided to members. KYHC manages, evaluates, and monitors the provision of healthcare services rendered to members to enhance access to, and provision of, appropriate services. KYHC seeks to facilitate communication and develop partnerships between members, practitioners, and providers. The focus is to develop and implement programs to encourage preventive health behaviors which can ultimately improve quality outcomes.

## HOURS OF OPERATION

KYHC's Utilization Management Department is available during regular business hours (Monday through Friday from 8 a.m. to 6 p.m. Eastern Time). After normal business hours, communications can be made via voicemail or facsimile. Staff will respond to all requests in a timely manner, generally within one (1) business day.

Utilization management services include the areas of utilization management, case management, disease management, and quality review. Case management and disease management are available at no extra cost.

Contact Information for utilization management services is as follows:

**Utilization Management**

**1-855-635-5580**

[www.mykyhc.org](http://www.mykyhc.org)

## UTILIZATION MANAGEMENT PROGRAM

KYHC's Utilization Management Program (UMP) is designed to ensure members of KYHC receive access to the right care at the right place and right time. The 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.

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 KYHC 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.

## CONCURRENT UM

A concurrent review is any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care. Requests are expedited when they are received for urgent care.

For the purposes of concurrent review, acute inpatient care is always considered to represent urgent care. KYHC staff case managers and physician reviewers may determine on a case-by-case basis which other cases represent urgent care. Members, practitioners and member representatives may request expedited concurrent review decisions; however, KYHC is not obligated to treat each request for an expedited decision as urgent.

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If KYHC receives a request for an expedited decision that does not appear to represent urgent care, the case will be referred to the medical director for determination of whether or not the review should be expedited. If the case is determined as non-urgent, KYHC will inform the requestor that standard time frames will apply to the request along with the reason for the decision.

The case manager will attempt to call the practitioner or designated facility representative to conduct concurrent review; however, *it is the responsibility of the member or practitioner, not KYHC, to ensure that concurrent reviews are conducted in a timely fashion.* KYHC will not retrospectively deny coverage for services when prior approval has been given *unless* the approval was based on fraudulent, materially inaccurate, or misrepresented information submitted by the covered person, authorized person or Provider.

Clinical information obtained for a concurrent review decision includes that which is reasonably necessary to apply the relevant medical necessity criteria. The information obtained should at least include:

- The member's current health status, including: clinical exam findings, diagnostic testing results (as appropriate)
- An assessment of treatment progress
- The reason for the requested extension of treatment
- The requested length of the extension
- Changes, if any, to the treatment plan

Decisions *not to authorize* at concurrent review may be made for the following reasons:

- The case no longer meets medical necessity
- There is insufficient information to authorize continued care
- The treatment plan previously approved is not being followed
- The member refuses to comply with treatment that is deemed reasonable and necessary to improve the member's symptoms
- A benefit limit or exclusionary criterion has been met

## RETROSPECTIVE UM

Retrospective review (or retro review) decisions are those for care or treatment that required a pre-service or concurrent review and the review was not completed. Retrospective review is conducted when requested by a member, practitioner or member representative. Review determinations are based on the information that was, or should have been, available to the treating practitioner at the relevant stage of treatment. Retro reviews require the completed medical record for the treatment time period under review.

**IMPORTANT:** A retrospective review must be *completed before* the provider submits a claim for payment. If a claim is received for a service that required prior authorization or concurrent review and there is no authorization on file then the claim will deny without medical review. The review must be completed prior to submission of the claim to meet administrative requirements for coverage.

## UM COMMITTEE

As a part of KYHC's ongoing process of updating and evaluating its Utilization Management Program, KYHC sponsors a UM Committee. The UM Committee consists of staff and plan providers. This committee is tasked with reviewing UM criteria and goals to update the UM plan. Providers that would like to participate in this committee, or if you know someone who would like to participate, should contact KYHC Provider Services for more information.

## CASE MANAGEMENT

KYHC believes that the health care a member receives is most effective when there exists a continuous effort to maintain the highest level of continuity and coordination of care throughout the continuum of the member's care. We seek to maintain continuity and coordination through our case management department. The case management department includes several programs: discharge planning, general case management, complex case management, and coordination of care.

### Case Managers

Case managers are licensed clinicians with case management experience. Each member enrolled in case management will be assigned a primary case manager based on primary condition (physical health or behavioral health) who will be responsible for overseeing the member's entire plan of care. This will include, but not be limited to, participation in inpatient rounds with concurrent review nurses to assist with discharge planning and coordination with the member's treating providers. Case managers will perform assessments, develop care plans, provide educational resources and follow up in conjunction with the team.

### Discharge Planning

Discharge planning begins on admission to treatment with the identification of any limitations, barriers or factors that could affect discharge or follow-up. For acute inpatient or other high intensity levels of service, the case manager is in regular contact with the treating practitioner or facility representative. If assistance is needed in securing follow up treatment or access to resources, the case manager will then refer the case to the discharge planner. The discharge planner will provide care coordination and as needed, refer the member for Case Management (CM) if needed.

### Complex Case Management

Complex case management is a process that identifies high-risk or high-cost members, assesses treatment options and opportunities to coordinate care, designs treatment programs to improve quality and efficacy of care, controls costs and manages member care to ensure the optimum outcome. Concentrating for the most part on catastrophic or chronic cases, KYHC's case manager nurses will manage diagnoses such as serious traumas, cancers, organ transplants, spinal cord injuries, multiple chronic illnesses and/or chronic illnesses that result in high utilization.

A designated case manager, who is a registered nurse, is responsible for managing these complex cases to ensure high quality, cost effective and appropriate utilization of health services. KYHC's case manager acts as a member advocate, seeking and coordinating creative solutions to a member's health care needs without compromising quality health outcomes for selected medical diagnoses. The case manager contacts KYHC members by phone and mail. The case manager is able to act as a resource, educator and/or coordinator of all medical care if needed.

## DISEASE MANAGEMENT

Disease Management (DM) is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. DM is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. DM programs will include the following: asthma, COPD, hypertension, heart failure, diabetes and high risk pregnancy management. Physicians can refer members for disease management services by calling the disease management department at **1-855-635-5580**.

Members enrolled into a DM program will receive some level of intervention, which may include, but is not limited to: identification, assessment, disease specific education, reminders about preventive/monitoring services, assistance with making needed appointments and transportation arrangements, referral to specialists as needed, authorization for services and/or medical equipment, coordination of benefits, and coordination with community-based resources. Education is a crucial component of the disease management program. Education will be presented to members and their treating physicians and may be provided through mailings and telephone calls.

## MEDICAL NECESSITY AND REVIEW CRITERIA

### Clinical Decisions

KYHC affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. KYHC does not reward practitioners or other individuals for issuing denials of service or care. KYHC prohibits the use of incentives that encourage inappropriate utilization management decision-making.

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 KYHC's 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 KYHC members as healthcare services, supplies or equipment provided by a licensed healthcare professional within the scope of their practice 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
- Not being sought as a way to potentially avoid legal proceedings, incarceration or other legal consequences.

### Review Criteria

KYHC 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. Kentucky Health Cooperative also utilizes Medicare National Coverage Determinations to assist in utilization review.

The Medical Necessity Criteria used by KYHC are designed to be clinically flexible, covering a wide range of clinical circumstances and presentations. Such criteria, however, cannot cover every potential set of circumstances. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determinations 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.

KYHC approved Medical Necessity Criteria are made available to all practitioners. Medical Necessity Criteria developed by KYHC are found in the documents section of our provider portal. A paper copy is available by calling Provider Services. KYHC's General Medical Necessity Criteria are also available on the provider portal and paper copy is available by contacting Provider Services. Medical Necessity Criteria developed by other organizations and adopted by KYHC are available for review on a case by case basis at the offices of KYHC.

### **New Technology**

KYHC will consider application of new technologies when coverage is requested. In instances where no InterQual criteria exists, the Medical Director shall consult all available medical literature. Additionally, the UM Committee is charged with evaluating new technologies or new applications of existing technologies for inclusion in our benefit plan.

### **Emergency Services**

KYHC covers emergency services necessary to screen and stabilize members without prior authorization in situations where a prudent layperson, acting reasonably, would have believed that a medical emergency condition existed. When adjudicating claims for emergency services, KYHC reviews the presenting symptoms and behaviors, not just the discharge diagnoses.

### **Second Opinion**

A second opinion may be requested when there is a question concerning diagnosis or options for surgery or other treatment of a health condition or when requested by any member of the member's health care team, including the member, parent and/or guardian, or a social worker exercising a custodial responsibility, may request a second opinion. Authorization for a second opinion shall be granted to a network practitioner or an out-of-network practitioner if there is no in-network practitioner available. The second opinion will be provided at no cost to the member.

### **CONTINUATION OF CARE – PROVIDER TERMINATION**

In the event that a provider leaves KYHC's provider network, KYHC will provide members with continued access to said provider (some exceptions do apply) for up to 90 days beyond the termination date or through the period of active treatment, whichever is less, for members in an active course of treatment at the time of termination. KYHC will also allow those members in the second or third trimester of pregnancy continued access to the provider through the postpartum period. KYHC endeavors to work with practitioners who have resigned or been terminated to develop reasonable transition plans for each member in treatment with the practitioner at the time of termination or resignation.

## CONTINUATION OF CARE – BENEFITS EXHAUSTION

KYHC attempts to maximize each member's benefit. Exhaustion of benefits can result in a disruption of necessary treatment and loss of therapeutic gains made by the patient. If, despite KYHC's efforts, a member exhausts his/her benefit while in an outpatient level of care and flexing benefits is not an option, KYHC will contact the member to inquire if the member would like assistance to find appropriate treatment resources. If the member wishes assistance, KYHC will work with the member and the practitioner to determine the best course of action. In some cases, KYHC will refer the member to community resources that may be able to assist the member.

## 10.0 QUALITY IMPROVEMENT (QI) PROGRAM

### QI OVERVIEW

Kentucky Health Cooperative, Inc. (“KYHC”) will be serving people throughout the Commonwealth and will be assisting them in overcoming barriers to healthcare. To ensure that KYHC provides this care, the Quality Improvement Committee (QIC) oversees the monitoring and evaluation of healthcare and services provided to KYHC members.

The QIC includes KYHC and MHNet (mental health benefits vendor) staff physicians and pharmacists, KYHC network providers, and KYHC staff. Demographic and health characteristics, including disease categories and risk status of members, are reported and analyzed by this group to guide the monitoring and evaluation of clinical issues. Indicators may be selected and monitored for a variety of demographic groups including:

- Infants and children
- Pregnant women
- Adult males
- Adult females

One of KYHC’s QI program objectives is to perform quality review of key clinical and service indicators to assess and improve member and practitioner satisfaction.

These clinical and service indicators include reviews of:

- Member and provider complaints for care or service.
- Sentinel events defined as any event involving member care that warrants further investigation for quality of care concerns.
- National Committee for Quality Assurance’s (NCQA’s) Healthcare Effectiveness Data and Information Set (HEDIS®).
- Application of current clinical guidelines (clinical guidelines are on KYHC’s Web site)
- Auditing of medical record documentation and continuity and coordination of care standards.
- Health outcome intervention studies or activities.

KYHC looks to its provider network to participate in quality improvement committees, special ad hoc work groups, and its medical records review activities to improve the health and quality of life of its members.

### ANALYSIS AND AUDIT

The QI Methodology describes the analysis of demographic and health profiles of the membership, including high-volume disease, age and gender analysis, and ethnicity analysis. The demographic and health profile is presented to the QIC for review. This profile is utilized in the selection of study topics relevant to the population served by KYHC.

This analysis will be conducted at least annually and includes:

- Age/sex distribution
- Hospitalizations by primary diagnosis
- Hospitalizations or post-hospitalization outcome (e.g. readmissions, complications)
- Primary care visits by primary diagnosis
- Specialty visits by primary diagnosis
- Prescriptions by therapeutic category
- Complaints and appeals by type
- Member satisfaction surveys
- Disenrollment studies
- Public health reports published by national, state or local agencies

In addition to this analysis, KYHC plans on monitoring and evaluating the care received by members in various care settings. To accomplish this review, KYHC plans on auditing care settings, including:

- Inpatient hospitalization
- Ambulatory care
- Home care

A copy of our QI Program Description can be downloaded from the [www.mykyhc.org](http://www.mykyhc.org) Web site or contact Clinical Care Integration Department at **1-855-635-5580**.

## 11.0 OVERVIEW OF HEDIS®

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used set of health care performance measures in the managed care industry in the United States. HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA).

HEDIS was designed to allow consumers the ability to compare health plan performance to other plans both nationally and regionally. HEDIS is one component of NCQA's accreditation process.

## 12.0 OVERVIEW OF CAHPS

Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. CAHPS is another component of NCQA's accreditation process.

## 13.0 CLINICAL PRACTICE GUIDELINES

Kentucky Health Cooperative, Inc. (“KYHC”) adopts evidence-based Clinical Practice Guidelines (CPGs) for certain medical conditions. These guidelines are reviewed by the QIC annually or whenever changes have been made and published. A comprehensive list of CPGs is available on the [www.mykyhc.org](http://www.mykyhc.org) Web site. Providers will be notified via newsletter announcements and directed to our Web site. Measurement of compliance with CPGs will be analyzed using claims and medical record audit data.

## 14.0 PREVENTIVE HEALTH GUIDELINES

Kentucky Health Cooperative, Inc. ("KYHC") adopts evidence-based preventive health guidelines for perinatal care; care for children up to 24 months old; care for children 2-19 years old; care for adults 20-64 years old; and care for adults 65 years and older. These guidelines are reviewed by the QIC annually or whenever changes have been made and published. A comprehensive list of preventive health guidelines is available on the [www.mykyhc.org](http://www.mykyhc.org) Web site. Providers will be notified via newsletter announcements and directed to our Web site. Measurement of compliance with preventive health guidelines will be analyzed using claims and medical record audit data.

## 15.0 PREVENTIVE CARE

THE FOLLOWING IS A PARTIAL LIST OF PREVENTIVE CARE GUIDELINES ADOPTED BY KENTUCKY HEALTH COOPERATIVE INC. ("KYHC"):

### IMMUNIZATIONS

KYHC requests that all members be immunized unless medically contraindicated. Visit [www.kyhc.org](http://www.kyhc.org) for a direct link to the Centers for Disease Control and Prevention's recommended immunization schedule for children and adults.

### RECOMMENDED PREVENTIVE CARE

Accurate identification and treatment are integral components of successful disease control efforts.

- HIV screen – USPSTF (2005) strongly recommends that clinicians screen for HIV in all adolescents and adults at increased risk for HIV infection. The USPSTF makes no recommendation for or against routinely screening for HIV in adolescents and adults who are not at increased risk for HIV infection.
- HPV Vaccine – Centers for Disease Control and Prevention's National Immunization Program and the federal Advisory Committee on Immunization Practices have recommended the use of the HPV vaccine.

### CANCER SCREENINGS

Breast cancer screen – USPSTF (2009) recommends a biennial screening mammography for women aged 50 to 74 years. The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms.

Cervical cancer screen – USPSTF (2012) recommends screening of women ages 21 to 65 years every 3 years or for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years. (These recommendations apply to women who have a cervix, regardless of sexual history and do not apply to women who have received a diagnosis of a high grade precancerous cervical lesion or cervical cancer, women with in utero exposure to diethylstilbestrol, or women who are immunocompromised (such as those who are HIV positive)).

Colon cancer screen – USPST (2008) recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.

### QUIT NOW KENTUCKY: KENTUCKY TOBACCO PREVENTION AND CESSATION PROGRAM QUITLINE

Tobacco use and tobacco-caused disease counseling (USPSTF 2003) includes a recommendation that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. Providers are encouraged to discuss tobacco cessation with members. Tobacco cessation counseling and prescription cessation aids are covered by and billable to KYHC. Preferred tobacco deterrent agents include: bupropion SR 150, Chantix®, Commit lozenges®, Nicoderm®, Nicorette®, nicotine gum, and nicotine patch. Medication plus counseling provides additional benefits. The effectiveness of counseling is comparable to pharmacotherapy alone. Even brief counseling is effective in facilitating quit attempts.

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Additionally, the Kentucky Tobacco Quitline is a free and confidential resource that is available to Kentucky residents. If you have tobacco users you would like to refer to the Quitline, you may do so by utilizing using the fax referral and/or online referral form found on the Quitline website at [http://quitnowkentucky.org/Providers\\_partners](http://quitnowkentucky.org/Providers_partners). The Quitline can be reached at **1-800-QUIT-NOW**, if you have any questions about the service.

## DIABETES CARE

Diabetes is a chronic illness that requires ongoing medical care and member self-management education to prevent acute complications and to reduce the risk of long-term complications.

- Hemoglobin A1c (HbA1c) – at least two (2) times a year in members who are meeting treatment goals (and who have stable glycemic control)
- A1c – test quarterly in members whose therapy has changed or who are not meeting glycemic goals
- Retinal eye exam – at least annually
- LDL-C screen – at least annually
- Nephropathy screen – at least annually, and medical attention for nephropathy, upon initial assessment and reassessments
- Blood pressure screen – upon initial assessment and reassessments
- Individualized treatment – as needed to achieve treatment goals, preferably provided by a registered dietician familiar with the components of diabetes medical nutrition therapy
- Physical activity – a regular physical activity program, adapted to the presence of complications, is recommended for all members with diabetes who are capable of participating
- Preliminary assessment of psychological and social status should be included as part of the medical management of diabetes; psychosocial screening should include, but is not limited to, attitudes about the illness, expectations for medical management and outcomes, affect/mood, general and diabetes-related quality of life, resources (financial, social and emotional) and psychiatric history

KYHC employs disease managers to work with these members to help them and you manage their care and improve outcomes over time. Simply contact KYHC and ask for diabetes disease management to refer a member and/or to access our educational materials.

***See the USPTF A and B Adult Preventive Guidelines and the AAP Bright Futures Pediatric Guidelines links on KYHC Web Site ([www.mykyhc.org](http://www.mykyhc.org)) for a list of all Preventive Health Guidelines***

## 16.0 COMPLAINT AND APPEAL PROCESS

Kentucky Health Cooperative, Inc. ("KYHC") makes every reasonable effort to avoid disagreement with members, practitioners and providers related to UM decisions. If unsatisfied with a UM decision, the member and member representative (including treating practitioner) have the right to initiate an appeal of the decision. There are three types of UM appeals: standard prior authorization appeals, expedited prior authorization appeals and retro (post service) appeals.

**Note:** *When an appeal involves an approved ongoing course of treatment to be provided over a period of time or number of treatments that KYHC has decided to reduce or terminate, KYHC continues coverage for the approved ongoing course of treatment without liability to the member until the member is notified of the appeal decision or until the approved ongoing course of treatment has been provided, whichever comes first.*

Members are notified in the initial UM adverse determination notification letter that the member, upon request, can have access to and copies of all documents relevant to the member's appeal free of charge.

An appeal is conducted by one or more appeal reviewers that: were not involved in the UM adverse determination that is the subject of the appeal; are not subordinates of any person involved in the UM adverse determination that is the subject of the appeal. One of the appeal reviewers, for appeals involving medical necessity or clinical appropriateness, including whether a particular treatment, drug or other item is experimental or investigational, is a same or similar specialist. Appeal reviews are conducted by appeal reviewers who are: physician reviewers if the appeal is of a denial based on medical necessity or clinical appropriateness or Individuals with appropriate knowledge, based on the subject of the appeal, if the appeal is of a denial based on benefit or administrative criteria.

### MEMBER REPRESENTATIVES

At any time during the appeal process, a member may choose to designate a member representative to participate in the appeal process on his/her behalf. Members are informed of their right to have a member representative act on their behalf in their EOC and at all levels of appeal and in the initial denial notification as follows:

"You have the right to be represented by anyone you choose, including an attorney and have that representative act on your behalf at all levels of appeal. You can also name a relative, friend, advocate, doctor, or someone else to act for you."

Members and member representatives have the right to submit written documents and other materials relevant to the appeal. For more information on how to appoint a member representative, contact **1-855-OUR-KYHC (1-855-687-5942).**

### PRACTITIONER AND FACILITY COMPLAINTS OR APPEALS

#### Peer-to-Peer Review

Practitioners who receive an adverse determination based on medical necessity may request a peer-to-peer review within 10 calendar days of the denial. The provider must contact KYHC Medical Management Department and provide three available dates and times to schedule a personal discussion with KYHC's Medical Director or plan pharmacist reviewer who rendered the determination. Providers may also obtain a copy of the guidelines used by the reviewer to deny or modify a service request.

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## CLAIMS PAYMENT INQUIRIES OR APPEALS

If a provider believes an error has been made during claims adjudication, the provider should first contact KYHC's provider call center at **1-855-OUR-KYHC (1-855-687-5942)**. A call center agent will review the claims adjudication and the edits applied to the claims. If after reviewing the claim with a call center agent, the provider believes an error has been made, the provider may appeal the claim's adjudication in writing. Providers should submit in writing the following information:

- Patient name
- Patient date of birth
- Subscriber name
- Subscriber number
- Date of service
- Justification for appeal

Providers should submit this information on their letterhead stationary, signed by an authorized representative of the provider's staff. Mail a copy of the appeal request and all associated documentation, including copies of remittance advices to:

Kentucky Health Cooperative Provider Appeals  
PO BOX 9107  
Foxboro, MA 02035

The provider will receive written disposition of the appeal within 30 business days.

## LEVEL II POST-SERVICE APPEALS

Post-service appeals of UM adverse determinations are available when the member has already received the requested care or service that is the subject of the appeal. A post-service appeal may be initiated by the member or member representative (including treating practitioner on behalf of the member). Requests for post-service appeals may be submitted to KYHC orally or in writing. The member has at least 60 days after notification of the UM adverse determination to file a post-service Appeal. The member or member representative has the right to submit written comments, documents or other information relating to the appeal. The appeals coordinator sends a written acknowledgement letter to the member within five (5) calendar days of receipt of the appeal.

## MEMBER COMPLAINTS AND APPEALS

### **A How To Guide: Appeal Rights**

KYHC denies a claim or coverage. What can you do? Members have the right to know why KYHC denied a claim or terminated their coverage as well as the right to appeal such an Adverse Benefit Determination (ABD). If you are dissatisfied with our decision, you can file for an appeal through our internal appeal process. You have 180 calendar days from receipt of the initial adverse determination to file an appeal with KYHC.

Kentucky Health Cooperative, Inc.  
Attn: Appeals Department  
9700 Ormsby Station Road, Suite 100  
Louisville, KY 40223

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## **What Exactly is an ABD?**

An ABD can involve a denial based on a determination by KYHC that a benefit (service, treatment, drug or device) is:

- Not medically necessary
- Considered experimental/investigational
- Excluded in the health plan
- The member did not follow the plan delivery rules
- Denied because the member is not a plan participant
- Denied because the plan was rescinded (withdrawn) because the member provided fraudulent information

## **How Does a Member Appeal an ABD?**

Appeals for ABDs must first be sent to KYHC to complete the internal appeals process, unless there is a medical urgency (see section regarding expedited appeals).

## **What Should I Include with My Appeal?**

The appeal request should include the member's name, provider's name, date of the service, member's mailing address, and an explanation of why the member believes KYHC should reverse its decision. Providers need to include any other information that supports the member's request. The provider may be contacted if assistance is needed with obtaining medical records.

## **Can I Appoint Someone to Represent Me?**

The member has the right to appoint another person to represent them through the appeals process. This person is called an authorized representative. In order to appoint an authorized representative, the member must sign and return an authorization form. Please call KYHC at **1-855-635-5580** for further assistance.

Internal appeals may be submitted by the member or an individual, including a provider authorized to act on behalf of the member. KYHC is required to respond within 30 days of receiving the member's appeal or three (3) days if it is an expedited (medical emergency) appeal. If, upon completion of the internal appeals process, KYHC continues to uphold its denial, the member will have the opportunity to request an impartial review of the denial. The final denial letter from KYHC will have the addresses needed to further appeal as well as the timeframe. The type of denial the member receives will determine what entity does the reevaluation.

## **Who Is Responsible for Conducting an Impartial Review?**

If the member's ABD is denied because:

- The benefit is not considered medically necessary/experimental/investigational, the appeal is sent to KYHC.
  - KYHC forwards the member's appeal, including their records regarding the member's denial, to an Independent Review Entity (IRE) which will make the determination.
- The benefit is limited or excluded in the member's health benefit plan.
  - The member will be directed by KYHC to write to the Health and Life Division of the Kentucky Department of Insurance for a coverage denial review and determination.
- A plan delivery rule is not followed or any other reason for an ABD.
  - The member will be directed by KYHC to write to the Consumer Protection Division of the Kentucky Department of Insurance for a review and decision.

## What Is an IRE?

An IRE is a company (not associated with your insurer) certified by the Kentucky Department of Insurance to perform medical external reviews. The IRE uses experts to review the denial and decide whether the request for coverage was medically necessary and covered under the plan. The IRE can take up to 45 days for a standard appeal, but no more than 72 hours to make a decision for an expedited or emergency appeal.

## What Urgent Medical Situations Qualify for an Expedited Appeal?

An appeal for a denial of a benefit based on medical necessity shall be considered an expedited appeal when the member's doctor certifies in writing that one (1) or more of the following apply:

- The member is hospitalized
- It is determined to be urgent care
- The decision to deny coverage could seriously jeopardize the member's life, health or the ability to regain function
- The expedited internal and expedited external appeals can be reviewed at the same time
- If in the opinion of the member's treating physician, the member would be subjected to severe pain that cannot be adequately managed without the care that is the subject of the review
- The treatment is considered experimental/investigational and it is determined the treatment will be significantly less effective if not initiated promptly

The member also has the right to request an IRE appeal. The member may request an IRE appeal at the same time that the member requests an expedited appeal.

## Is Additional Help Available?

Yes, if there are any questions regarding appealing an ABD or other health insurance matters regarding fully-insured health benefit plans issued in Kentucky, contact the Consumer Protection Division:

**Call: 800-595-6053 (Kentucky residents only) or 502-564-6034**

Ask to speak to a consumer complaint investigator

Kentucky Department of Insurance

Consumer Protection Division

P.O. Box 517

Frankfort, KY 40602

**Online:** [http://insurance.ky.gov/Home.aspx?Div\\_ID=4](http://insurance.ky.gov/Home.aspx?Div_ID=4)

In addition, The Kentucky Health Insurance Advocate can assist individuals living in Kentucky with any type of plan.

**Call: 877-587-7222 (Kentucky only) or 502-564-6034**

Kentucky Health Insurance Advocate

P.O. Box 517

Frankfort, KY 40602

**Email:** [DOI.CAPombudsman@ky.gov](mailto:DOI.CAPombudsman@ky.gov)

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## QUALITY OF CARE ISSUES

KYHC has policies and procedures for registering and responding to oral and written complaints that include the documentation of the substance of complaints and actions taken, investigation of the substance of complaints, including any aspect of clinical care involved, notification to members of the disposition of complaints and the right to appeal, as appropriate, standards for timeliness and provision of language services for the complaint process.

## EXPEDITED APPEALS

Expedited appeals of UM adverse determinations are available in certain circumstances. An expedited appeal may be initiated by the member, member representative (including treating practitioner on behalf of the member). Requests for expedited appeals may be submitted to KYHC verbally or through facsimile. The appeal is initiated when the individual requesting the appeal notifies KYHC of his/her request. The request for an expedited appeal is immediately acknowledged upon receipt by the KYHC receiving the request for the expedited appeal. This notice may be accomplished by a documented telephone call to the member and followed up in writing.

When reviewing the appeal, if the available information suggests that the original UM adverse determination should be upheld, the physician reviewer attempts to contact the appellant by telephone to discuss the case and to obtain any relevant additional information. The first attempt to contact the appellant will be as soon as possible and no more than 24 hours after the request for the expedited appeal is received. If there is no response to the first call during normal business hours, the physician reviewer places a second call no sooner than one hour after the first call. If there is no response to the second call within 24 hours, the decision is rendered on the information available.

## CRITERIA FOR EXPEDITED APPEALS

An expedited appeal may be available concerning admission, continued stay, or other health care services for a member who has received emergency services but has not been discharged from the facility.

Expedited appeals can be granted when use of the timeframes for standard pre-service appeals:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment or;
- Could seriously jeopardize the life, health or safety of the member or others due to the member's psychological state or;
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request or;
- In the opinion of a practitioner with knowledge of the member's medical or behavioral healthcare condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

| Internal Appeal Time Frames       |                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Appeal Type                       | Acknowledgement                                                                   | Resolution Time Frame                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Prior Authorization (Pre-Service) | Acknowledgement letter is sent within five (5) business days of receipt of appeal | Resolution and notification within 30 calendar days of the date that Kentucky Health Cooperative received the request                                                                                                                                                                                                                                                                                                                                                                    |
| Retro (Post-Service)              | Acknowledgement letter is sent within five (5) business days of receipt of appeal | Generally resolution and notification within 30 calendar days of the date that Kentucky Health Cooperative received the request. This timeframe can be extend 15 days for circumstances beyond Kentucky Health Cooperative's control. Claimant will be notified of this extension prior to the expiration of the original timeframe. If additional information is needed from claimant, claimant will be notified and granted 45 days from receipt of notice to provide the information. |
| Expedited (must meet criteria)    | Immediate via phone                                                               | Resolution and notification within 72 hours of when Kentucky Health Cooperative received appeal                                                                                                                                                                                                                                                                                                                                                                                          |

## EXTERNAL APPEALS

All KYHC members have access to an external appeal or external expedited review, as appropriate, of an UM adverse determination through the Department of Insurance. An external review of an adverse determination may be requested by the member/member representative (including authorized person or a provider acting on behalf of and with the consent of the member). Request for an external review must be filed by the covered person within four (4) months (120 days) of receiving the final internal appeals notice. Members may contact the Consumer Protection Division at the Department of Insurance as listed below:

**Call: 877-587-7222 (Kentucky only) or 502-564-6034**

Kentucky Health Insurance Advocate

P.O. Box 517

Frankfort, KY 40602

**Email: [DOI.CAPOmbudsman@ky.gov](mailto:DOI.CAPOmbudsman@ky.gov)**

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## APPENDIX A

| Provider Services Representative<br>Territory Assignments |             |                                                       |                                     |           |                                         |             |
|-----------------------------------------------------------|-------------|-------------------------------------------------------|-------------------------------------|-----------|-----------------------------------------|-------------|
| Western Kentucky Area<br>(502) 785-3664                   |             | Central & Northern<br>Kentucky Area<br>(502) 498-5529 | Northeastern Area<br>(502) 694-1001 |           | Eastern Kentucky Area<br>(502) 785-3678 |             |
| Adair                                                     | Henderson   | Boone                                                 | Anderson                            | Lewis     | Bath                                    | Leslie      |
| Allen                                                     | Hickman     | Bullitt                                               | Bourbon                             | Lincoln   | Bell                                    | Letcher     |
| Ballard                                                   | Hopkins     | Campbell                                              | Boyle                               | Mason     | Boyd                                    | McCreary    |
| Barren                                                    | Livingston  | Carroll                                               | Bracken                             | Mercer    | Breathitt                               | Madison     |
| Breckenridge                                              | Logan       | Casey                                                 | Fayette                             | Nicholas  | Carte                                   | Magoffin    |
| Butler                                                    | Lyon        | Gallatin                                              | Fleming                             | Owen      | Clark                                   | Martin      |
| Caldwell                                                  | McCracken   | Green                                                 | Franklin                            | Pendleton | Clay                                    | Menifee     |
| Calloway                                                  | McLean      | Hardin                                                | Garrard                             | Robertson | Elliott                                 | Montgomery  |
| Carlisle                                                  | Marshall    | Jefferson                                             | Grant                               | Scott     | Estill                                  | Morgan      |
| Christian                                                 | Metcalfe    | Kenton                                                | Harrison                            | Shelby    | Floyd                                   | Owsley      |
| Clinton                                                   | Monroe      | Larue                                                 | Henry                               | Spencer   | Greenup                                 | Perry       |
| Crittenden                                                | Muhlenberg  | Marion                                                | Jessamine                           | Woodford  | Harlan                                  | Pike        |
| Cumberland                                                | Ohio        | Meade                                                 |                                     |           | Jackson                                 | Powell      |
| Daviess                                                   | Russell     | Nelson                                                |                                     |           | Johnson                                 | Pulaski     |
| Edmonson                                                  | Simpson     | Oldham                                                |                                     |           | Knott                                   | Rockcastle  |
| Fulton                                                    | Todd        | Taylor                                                |                                     |           | Knox                                    | Rowan       |
| Graves                                                    | Trigg       | Trimble                                               |                                     |           | Laurel                                  | Wayne       |
| Grayson                                                   | Union       | Washington                                            |                                     |           | Lawrence                                | Whitley     |
| Hancock                                                   | Warren      |                                                       |                                     |           | Lee                                     | Wolfe       |
| Hart                                                      | Webster     |                                                       |                                     |           |                                         |             |
| IPAs                                                      |             |                                                       |                                     |           |                                         |             |
|                                                           |             |                                                       | KYPCA<br>APCP                       | TPN       | LCPN                                    |             |
| Surrounding States                                        |             |                                                       |                                     |           |                                         |             |
| Illinois                                                  | Missouri    | Indiana                                               | Ohio                                |           | Tennessee                               | Virginia    |
| Alexander                                                 | Mississippi | Clark                                                 | Adams                               |           | Campbell                                | Buchanan    |
| Gallatin                                                  | New Madrid  | Crawford                                              | Brown                               |           | Clayborn                                | Dickenson   |
| Hardin                                                    |             | Floyd                                                 | Scioto                              |           | Hancock                                 | Lee         |
| Massac                                                    | Tennessee   | Harrison                                              | Lawrence                            |           | Hawkins                                 | Wise        |
| Pope                                                      | Clay        | Jefferson                                             |                                     |           | Johnson                                 |             |
| Pulaski                                                   | Davidson    | Perry                                                 | W. Virginia                         |           | Knox                                    | W. Virginia |
|                                                           | Henry       | Switzerland                                           | Cabell                              |           | Pickett                                 | McDowell    |
| Indiana                                                   | Lake        |                                                       |                                     |           | Scott                                   | Mingo       |
| Posey                                                     | Macon       | Ohio                                                  |                                     |           | Sullivan                                | Wayne       |
| Spencer                                                   | Montgomery  | Clermont                                              | **All Other States**                |           |                                         |             |
| Vanderburgh                                               | Obion       | Hamilton                                              |                                     |           |                                         |             |
|                                                           | Robertson   |                                                       |                                     |           |                                         |             |
|                                                           | Stewart     |                                                       |                                     |           |                                         |             |
|                                                           | Sumner      |                                                       |                                     |           |                                         |             |
|                                                           | Weakly      |                                                       |                                     |           |                                         |             |

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