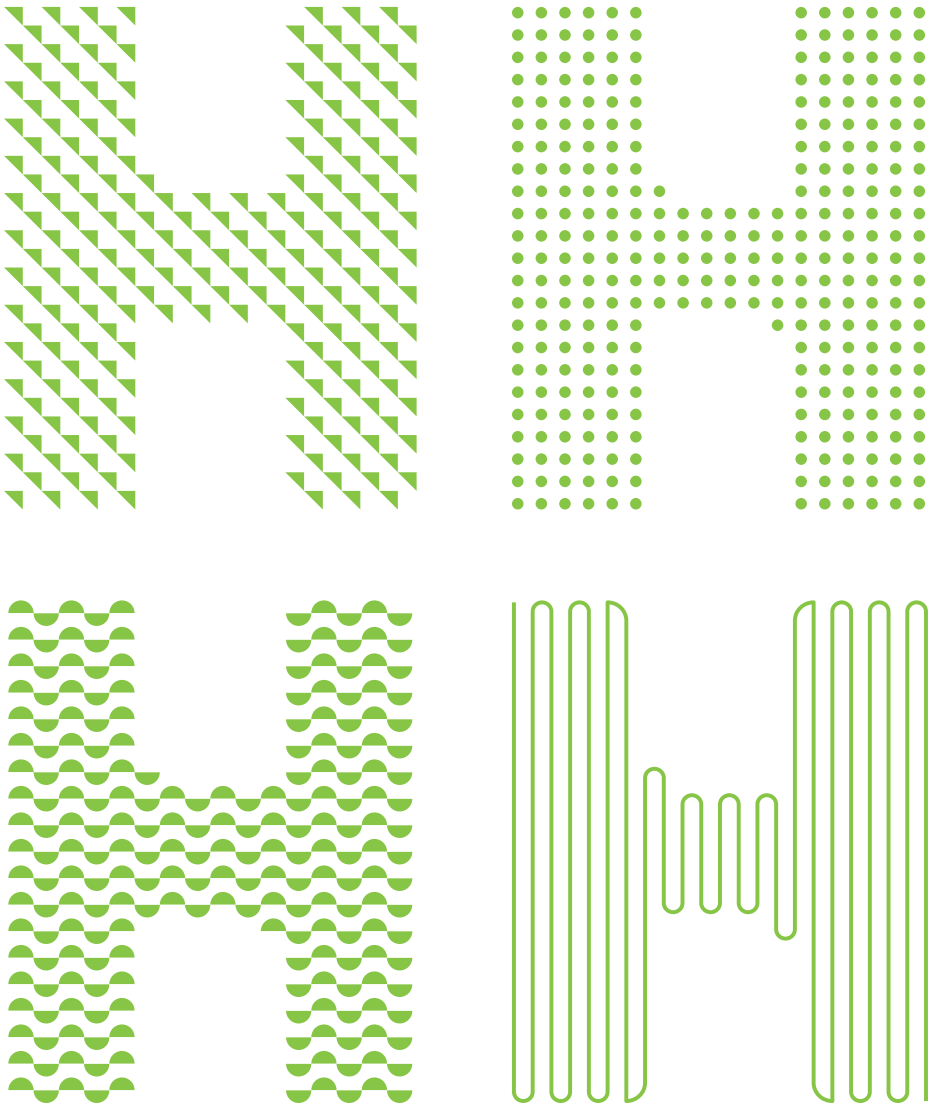

# 2024 Provider Manual

## HUMANA HEALTHY HORIZONS IN KENTUCKY

Humana Healthy Horizons in Kentucky

Humana Healthy Horizons in Kentucky is a Medicaid product of Humana Health Plan, Inc.

424603KY0324-A (HUMP7688) KYHKMD8EN

# Table of contents

# Welcome

## Welcome and thank you for becoming a participating provider with Humana Healthy Horizons® in Kentucky.

We strive to work with our providers to make it as easy as possible to do business with us. This strong partnership helps facilitate a high quality of care and respectful experience for our enrollees.

We are a community-based health plan that serves Medicaid consumers throughout the commonwealth of Kentucky.

Our goal is to provide integrated care for our enrollees. We focus on prevention and partnering with local providers to offer the services our enrollees need to be healthy.

As a managed care organization (MCO), Humana improves the health of our enrollees utilizing a contracted network of high-quality providers. Primary care providers (PCPs) within the network provide a range of services to our enrollees and coordinate patient care by referring them to specialists when needed and ensuring timely access to healthcare services and appropriate preventive services.

Humana distributes enrollee rights and responsibility statements to the following groups after their enrollment and annually thereafter:

- New enrollees
- Existing enrollees
- New providers
- Existing providers

## About us

Humana is the nation's premier health benefits innovator with roots in Kentucky. We leverage our deep Medicaid experience and capitalize on proven expertise, a diverse suite of resources and capabilities, established relationships, and infrastructure.

Humana has the expertise, competencies and resources to make healthcare delivery simpler, while lowering costs and improving health outcomes. We help you provide our enrollees with the highest quality of care through services such as:

- Care management and care transitions programs
- Analytical tools to identify enrollees who might benefit from special programs and services
- An ongoing focus on customer service, health education, and activities to promote health and wellness
- Community engagement and collaboration to ensure the comprehensive needs of enrollees are addressed
- Access to behavioral health services that includes crisis intervention and a dedicated hotline
- An award-winning history in enrollee services, training, clinical programs and customer satisfaction
- The ability to scale, innovate and provide ongoing support to our extensive provider network

## Humana makes a difference

Humana brings a history of innovative programs and collaborations to ensure our enrollees receive the highest quality of care. With a focus on preventive care and continued wellness, our approach is simple: We want to make it easier for our enrollees to get the healthcare they need, when they need it. Through community-based partnerships and services, we help our enrollees successfully navigate complex healthcare systems.

Humana has more than 60 years of managed care experience with the expertise and resources that come with it.

**Our services include:**

- Provider relations
- Enrollee eligibility/enrollment information
- Claim processing
- Decision-support informatics
- Quality improvement (QI)
- Regulatory compliance
- Special investigations for fraud, waste and abuse
- Enrollee services, including an enrollee call center and a 24-hour nurse advice line

**In addition to the above, our care management programs include the following:**

- Case management
- On-site case management (clinics and facilities)
- Emergency department diversion
  - Identification of enrollees with higher than normal emergency department utilization
  - 24-hour nurse advice line
- Maternal and healthy baby program
- Discharge planning and transitional care support
- Support with health-related social needs and other factors impacted by social determinants of health (SDOH)

Disease management programs for asthma and diabetes

## Humana Healthy Horizons in Kentucky provider representatives

Humana offers Provider Relations representatives to our contracted providers who specialize in the following:

- Assisting all network providers in navigating Humana Healthy Horizons resources
- Helping providers access resources for billing and coding issues
- Educating providers regarding new policy changes, system updates and availability standards
- Instructing on resolution processes and assisting with escalated issues
- Communicating important information with the provider network via meetings, newsletters, network notices and emails

Your Provider Relations representative will conduct a required yearly on-site visit to PCP offices to ensure compliance and provide education to include but not limited to the following areas:

- Access and availability standards
- Privacy practices
- Health Insurance Portability and Accountability Act (HIPAA) policies and procedures
- Patient rights and responsibilities
- Provider resources
- Cultural competency
- Case management programs
- Encounter submissions
- Grievance and appeals processes
- Kentucky Health Information Exchange (KHIE) participation
- Vaccines for Children program
- Enrollee disenrollment processes

To find out who your assigned Provider Relations representative is, please visit **Documents and Resources for Kentucky Medicaid**.

If you are unable to determine who your representative is, please email **KYMCDPR@humana.com**.

For Medicaid claims-related inquiries, please email **KYMCDPR@humana.com** and copy your Provider Relations representative.

## Communicating with Humana Healthy Horizons in Kentucky

**Enrollee Services: 800-444-9137** Monday through Friday, 7 a.m. to 7 p.m., Eastern time

**Provider Services: 800-444-9137** Monday through Friday, 8 a.m. to 6 p.m., Eastern time

**24-Hour Nurse Advice Line: 800-648-8097**

**Other helpful phone numbers:**

- Prior authorization (PA) assistance for medical procedures and behavioral health: **800-444-9137**
- Medication intake team (PA for medications administered in medical office): **866-461-7273**
- Medicaid case management: **888-285-1121**
- Availity Essentials™ customer service/tech support: **800-282-4548**

- Fraud, waste and abuse (FWA)
  - Special Investigations Unit (SIU) hotline: **800-614-4126** (Available 24 hours a day, seven days a week)
  - Ethics Help Line: **877-5-THE-KEY (877-584-3539)**
- Contact information for our EviCore, WholeHealth Living (a brand of Tivity Health) and Avēsis partners can be found in the Prior Authorization Partners section of this manual.

**Mail**

**General correspondence**

**Humana Healthy Horizons in Kentucky**
P.O. Box 14601
Lexington, KY 40512

**Provider grievance and appeals**

**Grievance and Appeals Department**
P.O. Box 14546
Lexington, KY 40512-4546
Fax the form or letter to **800-949-2961**

**Enrollee grievance and appeals**

**Humana Healthy Horizons in Kentucky**
P.O. Box 14546
Lexington, KY 40512-4546

**Claims**

**Humana Healthy Horizons in Kentucky**
P.O. Box 14601
Lexington, KY 40512-4601

**Fraud, waste and abuse**

**Humana Healthy Horizons in Kentucky**
Special Investigations Unit
1100 Employers Blvd.
Green Bay, WI 54344

## Availity Essentials

Humana uses Availity Essentials to supply providers with enrollee references and claim data for multiple payers using one sign-in. Availity Essentials includes access to:

- Eligibility and benefits
- Referrals and authorizations
- Claim status
- Claim submission
- Submission of disputes and appeals
- Remittance advice
- Enrollee summary
- Overpayment
- Electronic remittance advice (ERA)/electronic funds transfer (EFT)

To learn more, please call **800-282-4548** or visit **Availity.com**.

## Compliance and ethics

Humana serves a variety of audiences: enrollees, providers, government regulators and community partners. We serve them best by working together with honesty, respect and integrity. We are all responsible for complying with all applicable state and federal regulations along with applicable Humana policies and procedures.

Humana is committed to conducting business in a legal and ethical environment. A compliance plan has been established by Humana that:

- Formalizes Humana's commitment to honest communication within the company and within the community, inclusive of our providers, enrollees and employees
- Develops and maintains a culture that promotes integrity and ethical behavior
- Facilitates compliance with all applicable local, state and federal laws and regulations
- Implements a system for early detection and noncompliance reporting with laws and regulations; fraud, waste and abuse concerns; or noncompliance with Humana's policy and professional, ethical or legal standards
- Allows us to resolve problems promptly and minimize negative impact on our enrollees or business including financial losses, civil damages, penalties and sanctions

The following are general compliance and ethics expectations for providers:
- Act according to professional ethics and business standards.
- Notify us of suspected violations, misconduct, or fraud, waste and abuse concerns.
- Cooperate fully with any investigation of alleged, suspected or detected violations of applicable state or federal laws and regulations.
- Notify us if you have questions or need guidance for proper protocol.

For questions about provider expectations, please contact your **Provider Relations representative** or call Provider Services at **800-444-9137**.

We appreciate your commitment to compliance with ethics standards and the reporting of identified or alleged violations of such matters.

## Accreditation

Humana holds a strong commitment to quality. We demonstrate our commitment through programs based on national standards, when applicable. Humana holds accreditation from the National Committee for Quality Assurance (NCQA) for our Medicaid line of business.

## Helpful websites

Providers may obtain plan information from the **Humana Healthy Horizons in Kentucky website**. This information includes:
- Health and wellness programs
- Provider publications (including provider manual, newsletters and program updates)
- Pharmacy services
- Claim resources
- Quality resources
- What's new

For help or more information regarding web-based tools, please call Provider Services at **800-444-9137**.

## Enrollee enrollment and eligibility

**Medicaid eligibility**

Medicaid eligibility is determined by the Department for Community Based Services (DCBS) in the county where the enrollee resides.

The commonwealth of Kentucky provides eligibility information for enrollees assigned to Humana on a daily basis via the 834 file. Eligibility begins on the first day of each calendar month for enrollees joining Humana Healthy Horizons, with two exceptions:
- Newborns, born to an eligible mother, are eligible at birth.
- Enrollees who meet the definition of unemployed, in accordance with 45 CFR 233.100, are eligible on the date they are deemed unemployed.

## Medicaid redetermination process

Humana Healthy Horizons enrollees must complete the Medicaid eligibility redetermination process to ensure they don't lose their Medicaid coverage and benefits.

Kentucky DCBS sends enrollees a form by mail when it is time to initiate the redetermination process. Humana Healthy Horizons also reminds enrollees to complete the redetermination process or risk losing their coverage and benefits. If patients ask about completing the redetermination process please advise that it is required to maintain Medicaid coverage.

Enrollees can complete the process in one of these ways:

**Online**
Enrollees who applied for Medicaid online, should complete the redetermination process on the **Kynect website**, to complete the redetermination process.

**By Mail**
Enrollees can complete the Renewal Form for Medical Coverage (sent to Medicaid recipients in Kentucky) and return it to:

**DCBS Family Support**
P.O. Box 2104
Frankfort, KY 40602

By Phone
Call **855-306-8959**

**In Person**
Enrollees can visit their local DCBS county office. Office locations are **available online**.

## Newborn enrollment

Humana begins coverage of newborns on the date of birth when the newborn's mother is an enrollee of a Humana Healthy Horizons Medicaid plan. The delivery hospital is required to enter the birth record into the birth record system, Kentucky's Certificate of Live Birth, Hearing, Immunization and Lab Data (KY CHILD). That information is used to auto enroll the newborn deemed eligible within 24 hours of birth. Newborns then appear on the PCP's enrollee eligibility list after they are added to the Humana system. Providers must use the newborn's Medicaid ID on any claim submitted for that enrollee.

Please refer to the Verify Eligibility section of this manual for instructions.

## Automatic renewal

If Humana enrollees lose Medicaid eligibility, but become eligible again within 2 months, they are automatically reenrolled in Humana Healthy Horizons and assigned to the same PCP, if possible.

Humana and the Kentucky Cabinet for Health and Family Services' (CHFS) Department for Medicaid Services (Kentucky DMS) reminds all providers to check a patient's eligibility in **KYHealthNet** before providing services. In instances when KYHealthNet shows the person presenting for services is incarcerated and the status is incorrect:

- Your patient can update his or her eligibility by completing the MAP-INC form via **Humana.com/KentuckyDocuments** and faxing it to Medicaid Enrollee Services at **502-564-0039**.
- Your patient can update his or her eligibility through their Kynect account.
- You can call Kentucky DMS Medicaid Provider Services at **855-824-5615** to report the error.

## New enrollee kits

Each new enrollee household receives a new enrollee kit and an ID card for each person in the family joining Humana Healthy Horizons. New enrollee kits are mailed separately from the ID card.

The new enrollee kit contains:

- A welcome letter
- Basic information about the Humana Healthy Horizons plan and how to access benefits
- Information on how to obtain a copy of the Humana Provider Directory
- A health assessment survey
- Information about Humana's digital tools, designed to improve enrollee engagement

## Enrollee ID cards

All new Humana Healthy Horizons enrollees receive a Humana enrollee ID card. A new card is issued only when the information on the card changes, if an enrollee loses a card or if an enrollee requests an additional card.

The enrollee ID card is used to identify a Humana Healthy Horizons enrollee; it does not guarantee eligibility or benefits coverage. Enrollees may disenroll from Humana and retain their previous ID card. Likewise, enrollees may lose Medicaid eligibility at any time. Therefore, it is important to verify enrollee eligibility prior to every service. Please refer to the Verify Eligibility section of this manual for more information.

Information included on the enrollee ID card:

- Enrollee name
- Date of birth—Enrollee's date of birth
- Humana Healthy Horizons enrollee ID number—Use this number on claims.
- Medicaid ID number—Please do not use this number to bill Humana.
- PCP/clinic name—Enrollees choose a participating provider to be their PCP. If a choice is not made, a PCP will be assigned where appropriate.
- Enrollee Services—Phone number and TTY
- 24-hour Nurse Line—Phone number to reach a registered nurse, 24 hours a day, seven days a week
- Behavioral Health Hotline—Enrollees can call this hotline 24 hours a day, seven days a week, for mental health or substance use disorder (SUD) services.
- Website—Our website contains plan information and access to special functionality, like eligibility verification, claim and PA submission, Coordination of Benefits (COB) check, and more.
- Provider Services—Use this toll-free phone number if you have questions or wish to verify eligibility over the phone.
- Mail medical claims to:
  Humana Healthy Horizons in Kentucky Claims Office
  P.O. Box 14601
  Lexington, KY 40512-4601
- Pharmacy—Call Provider Services if you have questions about pharmacy benefits and services.

Please note: Humana Healthy Horizons may be notified by the commonwealth that an enrollee has lost eligibility retroactively. This occurs occasionally, and in those situations, Humana will take back payments made for dates when an enrollee lost eligibility. The take-back code will appear on the next Explanation of Payment (EOP) for impacted claims.

**English ID card:**



**Spanish ID card:**


## Disenrollment

Enrollees are disenrolled from Humana Healthy Horizons for several reasons. If an enrollee loses Medicaid eligibility, they lose eligibility for Humana Healthy Horizons benefits. Humana, DCBS or the enrollee can initiate disenrollment.

Enrollee disenrollment can be initiated for these reasons:

- Unauthorized use of an enrollee ID card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the ability to deliver care to the enrollee or other patients

Please notify Enrollee Services if one or all of the previously listed situations occur. Please see the Involuntary Dismissal section of this manual for procedures for dismissing noncompliant enrollees from your practice. We can counsel the enrollee, or in severe cases, initiate a request to Kentucky DMS for disenrollment.

It is at DMS' discretion as to whether it will forward to DCBS for actual disenrollment. If forwarded to DCBS, DCBS reviews each enrollee disenrollment request and determines if the request should be granted. Disenrollment from Humana Healthy Horizons always occurs at the end of the effective month.

## Involuntary dismissal

Participating providers can request that a Humana Healthy Horizons enrollee be involuntarily dismissed from their practice and assigned a new PCP for the following reasons:

- Incompatibility of the provider/patient relationship
- Enrollee has not used a service within one year of enrollment in the PCP's practice and the PCP has documented unsuccessful contact attempts by mail and phone on at least six separate occasions during the year
- Provider inability to meet the medical needs of the enrollee
- Enrollee is incarcerated

Below are the requirements per Humana policy a provider must follow to request involuntary dismissals of an enrollee from their practice:

A. Attempt communication either in person, by mail and/or phone with the enrollee, and document them within the enrollee's medical record.
   1. Make three communication attempts regarding incompatibility of the provider/patient relationship where the enrollee does not respond to recommended patterns of treatment or behavior, including:
      i. Noncompliance with medication schedules
      ii. Violating no-show office policies
      iii. Failing to modify behavior as requested
   2. Make six communication attempts when the enrollee has not used a service within one year of enrollment into the PCP's practice.
   3. Communicate at least once regarding the provider's inability to meet the medical needs of the enrollee.

B. The provider's office notifies the enrollee of dismissal by certified letter, which must include the following details:
   1. The reason for which the disenrollment is requested
   2. The specific dates of the documented unsuccessful education/communications attempts and/or communication that the provider is unable to meet the enrollee's needs
   3. If the provider is a PCP, notification of the enrollee that they must contact Humana Healthy Horizons Enrollee Services to choose another PCP

C. The provider must submit the enrollee dismissal notice to Humana for review and approval to ensure all required communication to the enrollee is completed and meets all requirements.

A copy of the letter must be mailed or faxed to Humana:
**Humana Provider Relations**
Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax: **800-949-2961**

The dismissing provider serves the affected patient until a new provider can serve the patient, barring ethical or legal issues.

When an enrollee misses three or more consecutive appointments, providers may request assistance from the Humana Care Management department by sending an email to KYMCDCaseManagement@humana.com.

Providers do not have the right to request an enrollee's disenrollment from their practice for the following:

- Change in the enrollee's health status or need for treatment
- Enrollee's utilization of medical services
- Enrollee's diminished mental capacity
- Disruptive behavior that results from the enrollee's special healthcare needs unless the behavior impairs the ability of the PCP to furnish services to the enrollee or others

Transfer requests shall not be based on race, color, national origin, disability, age or gender.

## Referrals for release due to ethical reasons

Humana providers are not required to perform treatments or procedures contrary to the provider's conscience, religious beliefs or ethical principles, in accordance with 42 C.F.R 438.102.

The provider refers the enrollee to another provider who is licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition. The provider must be actively enrolled with the commonwealth of Kentucky to provide Medicaid services to beneficiaries. The provider also must be in Humana Healthy Horizons' provider network.

In such circumstances, where the provider's conscience, religious beliefs or ethical principles require involuntary dismissal of the enrollee, the provider's office must notify the enrollee of the dismissal by certified letter.

The letter should include:

- Reason for the disenrollment request
- Referral to another provider licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition
- Instructions to contact Humana Healthy Horizons Enrollee Services at **800-444-9137** for assistance in finding a preferred in-network provider

A copy of the letter must be mailed or faxed to Humana:
**Humana Provider Relations**
Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax: **800-949-2961**

Please call Provider Services at **800-444-9137** if you have questions about disenrollment reasons or procedures.

## Verify eligibility

Enrollees are asked to present an ID card each time services are rendered. If you are not familiar with the person seeking care and cannot verify the person as an enrollee of the Humana Healthy Horizons plan, please ask to see photo identification.

Before providing all services (except emergency services), providers are expected to verify enrollee eligibility via the KYHealthNet Portal.

KYHealthNet is the commonwealth's web portal that offers real-time enrollee eligibility access and MCO enrollment information. It contains many of the tools necessary for enrollee administrative tasks. To find out more about KyHealthNet and to create an account, please visit KyHealth Net System.

KYHealthNet displays the enrollee's date of eligibility, termination, the MCO with which they are enrolled and the Medicaid plan.

Providers also have access to verification resources on Availity Essentials. You can check Humana enrollee eligibility up to 24 months after the date of service. You can search by date of service plus enrollee name and date of birth, case number, Medicaid (MMIS) number, or Humana Healthy Horizons enrollee ID number.

You can submit multiple enrollee ID numbers in a single request. (Please note: While Availity Essentials offers historical eligibility information, Humana recommends using KYHealthNet when verifying eligibility on the date of service.)

Each month, PCPs can view a list of eligible enrollees who selected or were assigned to them as of the first day of that month. Sign in to our provider portal at Availity.com to view or print your enrollee list. Eligibility changes can occur throughout the month, and the enrollee list does not prove eligibility for benefits or guarantee coverage. Please use one of the previously described methods to verify enrollee eligibility for the date of service.

## No-show or cancellation fees

Medicaid providers are not permitted to charge Kentucky Medicaid recipients fees for missing or cancelling appointments, per Kentucky DMS policy, even if it is the provider's policy or practice to do so for all patients. Providers may not seek reimbursement for a missed or canceled appointment. Instead, Kentucky DMS asks providers to document and report missed or canceled appointments for monitoring purposes.

KYHealthNet now has a panel for entering missed and canceled appointments. The commonwealth recognizes an enrollee missing an appointment or canceling with little notice is a loss of revenue for your organization and prevents another enrollee from receiving faster access to services. Please take a few seconds to provide us with information about missed or canceled appointments so we can act to reduce those cases through outreach and, if appropriate, care management. In the system panel, providers can enter information when a Medicaid patient misses or cancels a scheduled appointment(s). Providers can find a user guide and video to answer questions about entering information posted on the Kentucky DMS website.

## Copayment

Per Kentucky Revised Statute 205.6312, copayments are not required or utilized for Medicaid services.

## Enrollee support services and benefits

Humana Healthy Horizons provides a wide variety of educational services, benefits and supports to our enrollees to facilitate their use and understanding of our services, promote preventive healthcare and encourage appropriate use of available services. We are always happy to work with you to meet the healthcare needs of our enrollees.

## Enrollee services

Humana can assist enrollees who have questions or concerns about services, such as case management, disease management, emergent and appropriate nonemergent transportation, and benefits.

Representatives are available by telephone at **800-444-9137** Monday through Friday, 8 a.m. to 6 p.m., Eastern time, except on observed holidays. If the holiday falls on a Saturday, we will be closed on the Friday before. If the holiday falls on a Sunday, we will be closed the Monday after.

## 24-hour nurse advice line

Enrollees can call **800-648-8097** 24 hours a day, seven days a week. The toll-free number is listed on the enrollee's ID card. Enrollees have unlimited access with an experienced staff of registered nurses to talk about symptoms or health questions.

Nurses assess an enrollee's symptoms, offering evidence-based triage protocols and decision support using the Schmitt-Thompson Clinical Content triage system, the gold standard in telephone triage.

Nurses educate enrollees about the benefits of preventive care and can make referrals to our disease and care management programs. They promote the relationship with the PCP by explaining the importance of the PCP's role in

coordinating the enrollee's care.

Key features of this service include:
- Assessing enrollee symptoms
- Advice about the appropriate level of care
- Answering health-related questions and concerns
- Providing information about other services
- Encouraging the PCP–enrollee relationship

## Emergency behavioral health services

For mental or behavioral health services, enrollees should call a contracted behavioral healthcare provider in their area. The behavioral healthcare provider can give the enrollee a list of common problems with behavior health symptoms and talk to the enrollee about how to recognize the problems. Enrollees may call the Humana behavioral health toll-free number at **888-666-6301**.

**Behavioral health crisis hotline**
For emergency behavioral healthcare within or outside the service area, please instruct enrollees to go to the closest hospital emergency room or the closest recommended emergency setting. They should contact you first if they are not sure the problem is an emergency. Humana's emergency and crisis behavioral health services hotline, **833-801-7355**, is staffed by trained personnel 24 hours a day, seven days a week, toll-free throughout the commonwealth of Kentucky. Crisis hotline staff includes or has access to qualified behavioral health services professionals to assess, triage and address specific behavioral health emergencies.

Emergency mental or behavioral health conditions include:
- Behaviors that are a danger to the enrollee or others
- Inability to carry out actions of daily life due to functional harm
- Behaviors that cause serious harm to the body that may cause death

## Disease management

Humana Healthy Horizons enrollees with emerging conditions and those with chronic conditions are eligible for enrollment in our disease management programs. Enrollees who choose to participate in these programs receive educational information on how to better manage their condition and care options for them to discuss with their provider. Enrollees identified as high risk are assigned a medical or behavioral health clinician who helps educate, coordinate and provide resources to the enrollee to optimize their overall health.

Chronic and emerging conditions include:
- Asthma
- Heart disease
- Diabetes
- Obesity
- Tobacco use
- Cancer
- Infant mortality
- Low birth weight
- Behavioral health and SUD
- Enrollees with special healthcare needs
- And others as determined by the MCO

If you have Humana Healthy Horizons-covered patients with any of these chronic conditions, and you believe they would benefit from this program, please call us at **888-285-1121** or email us at KYMCDCaseManagement@humana.com.

## Care management – outreach

Humana Healthy Horizons provides comprehensive and integrated care management services through medical and behavioral health staff, social workers and outreach specialists. Humana Healthy Horizons provides one-on-one personal interaction and support for enrollees. Additionally, Humana Healthy Horizons coordinates with community-

based resources to assist enrollees with social determinants of health (SDOH), such as food, transportation to medical appointments, utilities, etc. For help with enrollees who need assistance with SDOH, please call **866-331-1577** or email us at **KYMCDPopulationHealth@humana.com**.

Humana Healthy Horizons' care management program provides a broad spectrum of educational and follow-up services for your patients. We offer individualized education and support for many chronic diseases. Care management is especially effective for reducing admission and readmission risks, managing anticipatory transitions, engaging noncompliant enrollees, reinforcing medical instructions and assessing social needs. Humana Healthy Horizons also has a care management program designed for educating pregnant women and first-time mothers on the importance of prenatal care, childbirth, postpartum care and infant care.

## Referrals

We encourage you to refer enrollees who might need individual attention to help them manage special healthcare challenges. For direct access to care management, population health, and maternity referrals or assistance, please contact us at the following:

- Care Management: call **888-285-1121**, by faxing a request to **833-939-131**2 or email us at **KYMCDCaseManagement@humana.com**.
- Population Health: call **866-331-1577**, or email us at **KYMCDPopulationHealth@humana.com**.
- Maternity: call **888-285-1121**, fax a request to **833-939-1312**, or email us at **KYMCDHumanabeginnings@humana.com**.

## Services

The Humana Healthy Horizons care management program is a fully integrated health management program, supporting a holistic approach to healthcare by integrating physical and behavioral health while also considering environmental factors that impact health, such as food insecurity, housing and other SDOH. We implement an integrated, personal approach, supporting enrollees from their initial assessment through the continuum of care with the goal of enrollees taking an active part in their healthcare and making healthy lifestyle decisions. We take an enrollee-centric approach, placing them at the center of the process and working to identify their health priorities to support them in meeting those goals. This approach also supports and enhances the care and builds on the treatment you provide to your patient. We stress the importance of establishing the medical home, identifying early and ongoing of barriers to care, and keeping appointments. When necessary, we assist in arranging transportation to the provider's office.

Humana encourages you to take an active role in your patient's care management program, and we invite and encourage you to direct and participate in the development of a comprehensive care plan as part of your patients' multidisciplinary care team. We believe communication and coordination are integral to ensure the best care for our enrollees.

## High-risk enrollees

Humana Healthy Horizons provides a comprehensive integrated care management model for our highest-risk enrollees. Utilizing nurses and social workers, this multidisciplinary approach integrates standards of practice to help enrollees overcome healthcare access barriers. Humana Healthy Horizons also strengthens provider and community resource partnerships by managing enrollees through a collaborative effort within a multidisciplinary care team.

High-risk enrollees often have multiple medical issues, socioeconomic challenges and behavioral healthcare needs. The multidisciplinary care management teams are led by experienced care managers that perform a comprehensive assessment with the enrollee. The assessment incorporates physical and behavioral health status, along with socioeconomic needs, to develop an individualized treatment plan. The Care Management team then sets an ongoing contact schedule to monitor outcomes and evaluate progress for possible updates to the care plan based upon enrollee needs and preferences. Your patient's care plan is viewable by accessing **Availity Essentials** or request a copy by calling us at **888-285-1121**.

## Prenatal care management

Humana has a program for perinatal and neonatal care management utilizing a staff of specialized nurses. Nurses are available to help manage high-risk pregnancies and premature births by working in conjunction with providers and enrollees. The staff's expertise includes a focus on patient education and support and involves direct telephone contact with enrollees and providers. Humana encourages our prenatal care providers to notify Care Management support

services at **888-285-1121** when an enrollee with a high-risk pregnancy is identified.

**Prenatal risk assessment forms (PRAFs)**

Humana is committed to help providers manage high-risk pregnancies. Humana asks prenatal care providers use the prenatal risk assessment forms (PRAFs) to communicate critical information about our pregnant enrollees. This information is made available to the Humana Healthy Horizons Care Management team for outreach to enrollees, as necessary.

Please remember the following guidelines when submitting PRAFs:

- Use a form designed for prenatal risk assessment documentation, such as the **American College of Obstetrics and Gynecologists** (ACOG) form, the **Hollister** form or the Pregnancy Risk Assessment Form provided by **Humana**. You may use your own office assessment form if you have one that captures the same information.
- Send completed forms no later than four weeks after the enrollee's first prenatal visit.
- Please be sure to include the enrollee's estimated delivery date (EDD) on the form.
- You may use the Notice of Pregnancy Form on our provider portal at **Availity.com**.
- We accept copies or originals by fax or email. Please fax forms to **833-939-1317** or email them to **KYMCDHumanaBeginnings@humana.com**.

Humana accepts up to three assessment forms per pregnancy if additional forms are needed for changes noted during subsequent visits.

## Go365 for Humana Healthy Horizons

Go365 for Humana Healthy Horizons® is a wellness program that offers enrollees the opportunity to earn rewards for taking healthy actions. Most of the rewards are earned when Humana receives the provider's claim for services rendered. Humana recommends all providers submit their claims on behalf of an enrollee by end of February 2025, allowing enrollees time to redeem rewards.

Go365 is available to all enrollees who meet the requirements of the program. Rewards are not used to direct the enrollee to select a certain provider. Rewards are nontransferable to other managed care plans or other programs.

Medicaid enrollees must download the Go365 for Humana Healthy Horizons mobile app and register for access to begin earning rewards. As enrollees complete key healthy actions, rewards accumulate on their Go365 account. Those rewards can be redeemed in the Go365 mall for e-gift cards to popular retailers.

Rewards are nontransferable and have no cash value. E-gift cards may not be used for tobacco, alcohol, firearms, lottery tickets and other items that do not supporting a healthy lifestyle.

Enrollees can qualify to earn rewards by completing one or more of the following healthy activities:

| Healthy behavior rewards | Details and limitations |
|---|---|
| **Breast cancer screening** | Annual $25 reward is available for female enrollees 40 and older who obtain a mammogram. |
| **Cervical cancer screening** | Annual $25 reward is available for female enrollees 21 and older who obtain a Pap test. |
| **Chlamydia screening** | Annual $25 reward is available for female enrollees who obtain a chlamydia screening when sexually active and as recommended by their healthcare provider. |
| **Colorectal cancer screening** | Annual $25 reward is available for enrollees 45 and older who obtain a colorectal cancer screening as recommended by their PCP. |
| **COVID-19 vaccine** | Annual $25 reward is available for enrollees 5 and older who upload a picture/file of their completed COVID-19 vaccine card.<br><br>Enrollees who were vaccinated prior to enrollment in Humana Healthy Horizons plan may upload their vaccination card within 90 days of enrollment to receive the reward.<br><br>New enrollees who were not vaccinated prior to enrollment in Humana Healthy Horizons have 90 days from completion of the vaccination to upload the vaccination card to receive the reward. |

| Healthy behavior rewards | Details and limitations |
|---|---|
| **Diabetic retinal exam** | Annual $25 reward is available for diabetic enrollees 18 and older who complete a retinal eye exam. |
| **Diabetic screening** | Annual $20 reward is available for diabetic enrollees 18 and older who obtain a screening with their PCP for HbA1c and blood pressure. |
| **Digital onboarding** | One-time $25 reward is available for downloading Humana's mobile Go365 app and completing the registration. |
| **Flu vaccine** | Annual $25 reward is available for enrollees who receive an annual flu vaccine from their provider, pharmacy or self-reporting if they received a vaccine from another source. |
| **Health Risk Assessment (HRA) completion** | One-time $50 reward is available for completing the HRA within 30 days of enrollment with Humana Healthy Horizons. |
| **HPV vaccine** | One-time $80 reward is available for enrollees who receive two doses of the HPV vaccine between their 9th and 13th birthdays. |
| **Level of care education** | Annual $10 reward is available for enrollees 19 and older upon watching a short educational video about when to access the emergency room. |
| **Notification of Pregnancy (NOP)** | $25 reward is available when pregnant enrollees notify Humana Healthy Horizons of pregnancy prior to delivery once per pregnancy. |
| **Postpartum visit** | $50 reward is available for all postpartum females who complete one postpartum visit within seven to 84 days after delivery once per pregnancy. |
| **Prenatal visits** | Pregnant enrollees can earn $10 per prenatal visit, up to 10 prenatal visits, for a total of up to $100 once per pregnancy. |
| **Tobacco and vaping cessation coaching** | Enrollees 12 and older who enroll in tobacco and vaping cessation coaching will have two opportunities to earn rewards annually:<br>• $25 reward for completing two calls within 45 days of enrollment in the program<br>• $25 reward for completing the full program |
| **Weight management coaching** | Enrollees 12 and older who enroll in weight management coaching will have two opportunities to earn rewards:<br>• $15 in rewards for completing a well-being checkup<br>• $15 in rewards for completing the program |
| **Well-child visits, (0-15 months)** | Up to $60 reward is available for enrollees who complete routine well-child visits. Enrollees can receive $10 in rewards per visit with a six-visit limit. |
| **Well-child visits, (16-30 months)** | $20 reward is available for enrollees who complete routine well-child visits. Enrollees can receive $10 in rewards per visit with a two-visit limit. |
| **Wellness visit** | Annual $25 reward is available for enrollees 3 and older for completing an annual wellness visit. |

## Equitable population health management (EPHM)

At Humana, we're putting health first by focusing on the elimination of unjust, avoidable and unnecessary barriers to health and healthcare. These barriers can be based on your background, where you live, the resources you have, or systemic factors like racism and discrimination. Equitable population health is a foundational element of Humana's enterprise mission and a core component of our managed care programs. Humana assesses enrollees to identify needs and preferences, employs strategies to improve health and well-being, and implements interventions for priority populations—enrollees with emerging risks, significant behavioral health (BH) and SDOH needs, and segments of our population experiencing health disparities. Our continuous quality improvement methodology measures data, tracks trends and monitors outcomes to adjust our approach and achieve the Humana Healthy Horizons triple aim—better health, better care and better value.

Humana knows providers have a huge role in helping us achieve the triple aim through population health, and increasing providers' EPHM capabilities requires access to accurate, actionable data. Humana tailors care models to support

providers with the tools they need to succeed. Using these tools, provider practices can focus on preventive care and improving health outcomes, quality and cost while elevating the overall experience for their patients and care staff.

## Availity Essentials

Humana's provider portal, Availity Essentials, assists providers in their efforts to achieve optimal performance under value-based payment (VBP) arrangements. Providers benefit from having a single location and consistent workflow to process transactions and securely access a wide range of financial, administrative and clinical transactions. Availity Essentials offers the following features:

- The Practitioner Assessment Form (PAF), available through Availity Essentials, is a comprehensive health assessment form healthcare providers can use to help document vital patient information during a face-to-face physical examination. The PAF is a valuable tool to assist in closing care gaps through improved coordination of care.
- Availity's Payer Spaces allows Humana Healthy Horizons to deliver information to providers securely. Humana developed proprietary applications within Payer Spaces to partner effectively with providers and share clinical information. Humana's Care Profile application enables providers to view attributed enrollees' contact information, assessments and care plans. The Humana Medical Record Management application enables seamless sharing of medical record information, including admission, discharge and transfer (ADT) data in near real time, between healthcare providers and care management teams through direct connection with electronic health records (EHR).
- Availity 360 supports providers in understanding their overall performance, aggregating up to 12 months of information across a number of data types and sources. Humana uses reports from Availity 360 to:
  - Evaluate transaction volumes
  - Identify enrollees who utilize services at a more frequent rate than baseline
  - Analyze error and denial trends
  - Recognize patterns that may indicate fraud, waste and abuse (FWA)
  - Evaluate specific criteria (e.g., enrollee belongs to a disease registry)

## Compass

Humana's proprietary population health platform, **Compass**, is a valuable tool for providers. Providers can request access to Compass (**https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=4650971**) through their Humana Healthy Horizons representative. Through Humana's robust data-sharing capabilities, we can give providers additional insight into their patient panel. These expanded population health data help our providers manage the health of their patients and better inform their outreach and care.

Compass compiles utilization, financial and clinical data that can be filtered so providers can identify patients or groups requiring additional support. About a dozen core reports are included in Compass with additional reports available on request. The following reporting types are what we currently share with providers:

- Quality reports identify Healthcare Effectiveness Data and Information Set (HEDIS®) gaps in care as established by NCQA guidelines. These reports are an actionable breakdown of open gaps in care by enrollee, with specific noncompliance reasons and suggested calls to action to aid providers in gap closure. Quality reports also include a detailed, comprehensive view of Humana enrollees with diabetes, including testing for nephropathy, body mass index (BMI) and medication adherence. HEDIS gaps and analyses are updated weekly.
- Census reports identify all attributed patients who are currently admitted into an inpatient care facility. They also identify enrollees recently discharged from inpatient care. These analyses are updated daily.
- Patient detail reports provide an in-depth look at each enrollee, including demographics, visit history, diagnoses, HEDIS gaps, authorizations, provider visits and clinical program participation.

Providers can access data and reports through the Compass platform at any time. Additional features of Compass include the ability to customize columns to accommodate the user's needs and desired views. Compass also has a new Key Performance Indicator dashboard available to external provider access users.

## Transportation

Kentucky DMS contracts with the Kentucky Transportation Cabinet, Office of Transportation Delivery to provide nonemergency medical transportation (NEMT) services to Medicaid recipients who cannot drive or do not have transportation to medical facilities. Transportation to pharmacies to pick up prescriptions is not a covered benefit. Please note that NEMT services do not include emergency ambulance and nonemergency ambulance stretcher services, as

Kentucky Medicaid MCOs are required to contract with providers for transportation of an emergency nature, including emergency ambulance and ambulance stretcher services.

For NEMT services, enrollees can call **888-941-7433** to get help with the closest transportation service available to them. A list of **transportation brokers and their contact information** is available online or by calling the Kentucky CHFS Customer Service line at **800-635-2570** Monday through Friday, 8 a.m. to 4:30 p.m., and Saturday 8 a.m. to 1 p.m., Eastern time. Enrollees must call 72 hours before the time the ride is needed.

Humana Healthy Horizons is responsible for covering emergency ambulance and nonemergency ambulance stretcher services. Please call Provider Services at **800-444-9137** if you need assistance.

## Interpreter services

Hospital and nonhospital providers are required to abide by federal and state regulations related to sections 504 and 508 of the Rehabilitation Act, Americans with Disabilities Act (ADA), Executive Order 13166 and Section 1557 of the Affordable Care Act (ACA) in the provision of effective communication. This includes in-person or video-remote interpretation for deaf patients and over-the-phone interpretation with a minimum 150 languages available for non-English speakers.

## Health education

Humana Healthy Horizons enrollees receive health information from Humana through a variety of communication methods, including easy-to-read newsletters, brochures, phone calls and personal interaction. Humana Healthy Horizons also sends preventive care reminder messages to enrollees via mail and automated outreach messaging.

## Covered services

**General services**

Humana Healthy Horizons, through its contracted providers, is required to arrange for the following medically necessary services for each enrollee:

- Alternative birthing services
- Ambulatory surgical center services
- Behavioral health services—mental health and SUD
- Chiropractic services
- Community mental health center services
- Dental services—including oral surgery, orthodontics and prosthodontics
- Durable medical equipment, including prosthetics, orthotic devices, and disposable medical supplies
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening and special services
- End-stage renal dialysis services
- Family planning services in accordance with federal/state law and judicial opinion
- Hearing services, including hearing aids
- Home health services
- Hospice services (non-institutional only)
- Independent laboratory services
- Inpatient hospital services
- Inpatient mental health services
- Meals and lodging for appropriate escorts of enrollees
- Medical detoxification, meaning management of symptoms during the acute withdrawal phase from a substance to which the enrollee is addicted
- Medical services—including but not limited to, those provided by physicians, advanced practice registered nurses, physician assistants and federally-qualified health centers (FQHCs), primary care centers and rural health clinics (RHCs)
- Organ transplant services—only those not considered investigational by the Federal Drug Administration (FDA)
- Other laboratory and X-ray services
- Outpatient hospital services
- Outpatient mental health services
- Pharmacy—including limited over-the-counter (OTC) drugs and mental/behavioral health drugs

- Podiatry services
- Preventive health services, including those currently provided in public health departments, FQHCs, primary care centers and RHCs
- Psychiatric residential treatment facilities (PRTFs) (Level I and Level II)
- Specialized case management services—for enrollees with complex chronic illnesses (includes adult- and child-targeted case management)
- Specialized children's services clinics
- Targeted case management
- Therapeutic evaluation and treatment—includes physical therapy, speech therapy and occupational therapy
- Transportation to covered services—includes emergency, ambulance stretcher services and NEMT
- Urgent and emergency care services
- Vision care—including vision examinations, services of opticians, optometrists and ophthalmologists

## Behavioral health and substance use services

Behavioral health and substance-use services are covered services for Humana Healthy Horizons enrollees. Humana Healthy Horizons recognizes behavioral health and physical health function as a part of the whole person, and one can affect the other. Therefore, Humana Healthy Horizons uses a holistic approach to addressing behavioral health and substance use. Humana Healthy Horizons provides a comprehensive range of behavioral health services, including:

- Outpatient coverage for medication management; therapy services, e.g., individual, group and family therapy; and case management offered through key providers
- A broad range of services for both behavioral health and SUDs, including intensive outpatient, partial hospitalization, crisis stabilization and long- and short-term inpatient stays based on medical necessity
- Access to community-based resources

Providers, enrollees or other responsible parties can call Humana Healthy Horizons at **888-666-6301** to verify available behavioral health and substance-use benefits and to seek a referral or direction for obtaining behavioral health and substance-use services. The Humana Healthy Horizons network focuses on improving the health of our enrollees through efforts aimed at increased well-being, using enrollee-centered, evidence-based practices. Our goal is to provide the level of care needed by the enrollee in the least restrictive setting—the right care, at the right time, in the right setting.

## Screening and evaluation

Humana Healthy Horizons requires that PCPs have screening and evaluation procedures in place for the detection and treatment of, or referral for, known or suspected behavioral health problems and disorders. PCPs may provide clinically appropriate behavioral health services within the scope of their practice. When assessing enrollees for behavioral health services, Humana Healthy Horizons and its providers must use the most current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. Humana Healthy Horizons may require use of other diagnostic and assessment instrument/outcome measures in addition to the most current version of the DSM. Providers should document DSM diagnosis and assessment/outcome information in the enrollee's medical record.

Humana Healthy Horizons provides training to network PCPs on how to screen and identify behavioral health disorders on Humana Healthy Horizons' behavioral health services referral process and on clinical coordination requirements for such services. Humana Healthy Horizons also includes coordination and quality-of-care training and new models of behavioral health interventions.

## Care management and care coordination

Humana Healthy Horizons enrollees have access to care managers who provide a holistic approach to addressing the enrollee's physical and behavioral healthcare needs as well as SDOH. Humana Healthy Horizons also offers chronic condition management programs for behavioral health and SUDs. Humana Healthy Horizons-contracted providers may contact Humana Healthy Horizons to refer enrollees needing care management assistance by calling **800-444-9137** or by emailing KYMCDCaseManagement@humana.com. Humana Healthy Horizons adheres to a "no wrong door approach" to care management referrals.

Behavioral health service providers are required to refer enrollees with known or suspected and/or untreated physical health problems or disorders to their PCP for examination and treatment, with the enrollee's or the enrollee's legal

guardian's consent. Behavioral health providers may only provide physical healthcare services if they are licensed to do so.

Humana Healthy Horizons assists with provider referrals, scheduling appointments and coordinating an integrated approach to the enrollee's health and well-being by coordinating care between behavioral health providers, PCPs and specialists. Behavioral health providers are required to send initial and quarterly summary reports to the enrollee's PCP and to refer enrollees for PCP follow-up on untreated physical health concerns when identified. For further information about our integrated care management programs, please refer to the section in this handbook on Enrollee Support Services and Benefits.

## Continuation of treatment

For enrollees receiving inpatient behavioral health services, Humana Healthy Horizons requires providers to schedule an outpatient follow-up appointment prior to the enrollee's discharge from the facility within seven days of the date of discharge. Behavioral health providers are expected to contact patients within 24 hours of a missed appointment to reschedule.

## Continuation of treatment for enrollees with a severe mental illness (SMI)

Behavioral health service providers are required to assign a case manager prior to or on the date of discharge and provide basic, targeted or intensive case management services as medically necessary to enrollees diagnosed with a severe mental illness (SMI) and co-occurring conditions who are discharged from a state-operated or state-contracted psychiatric facility or state-operated nursing facility for enrollees with SMI. The case manager and other identified behavioral health service providers shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws.

For enrollees with a diagnosed SMI who are transitioning from an institutional setting to a community-based living arrangement, behavioral health specialists and psychiatric institution staff must collaborate with Humana Healthy Horizons' care managers for transition planning purposes. This includes sharing the enrollee's person-centered recovery plan and level-of-care determination as a part of discharge planning and ensuring continuity of care.

## Urine drug testing (UDT) policy

Humana Healthy Horizons implemented the Kentucky DMS urine drug testing (UDT) policy, effective July 1, 2020. Humana Healthy Horizons now processes these claims for payment as indicated by the Kentucky DMS policy, per the provider's Humana Healthy Horizons contract agreement and/or the Humana Healthy Horizons out-of-network payment policy. Once the enrollee exceeds the benefit limit as established by the Kentucky DMS, Humana Healthy Horizons denies the claim.

Providers may appeal the claim denial. Humana Healthy Horizons recommends that providers submit medical records as supporting documentation to prove the medical necessity for the service with the appeal request.

Additionally, claims paid for UDT services that exceed the enrollees' benefit are reviewed for recovery. Humana Healthy Horizons recommends that providers submit medical records as supporting documentation to prove the medical necessity for the service when disputing an overpayment recovery.

If a provider does not agree with the decision on a processed claim, the provider has 60 calendar days from the date of the original claim submission denial to file an appeal.

For more information on appeals, please refer to the Grievance and Appeals section.

Visit the **KDMS UDT policy**, for more details.

For additional questions regarding this policy, please contact your Provider Relations representative.

## Telehealth services

**Virtual/telehealth behavioral health services—Arcadian**

For mental and behavioral health services, Arcadian behavioral health virtual visits are available in select primary care offices. Similar to using FaceTime or Skype, the enrollee uses a webcam and a screen to talk to a licensed behavioral health specialist. These virtual visits are private, confidential and take place in the doctor's office.

Arcadian scope of services:
- Diagnostic assessment
- Ongoing counseling
- E-prescribing
- Ongoing medication management
- Care coordination with provider office

Provider types:
- Psychiatrists
- Psychologists

**Virtual urgent care services—MDLive (telehealth)**
Humana Healthy Horizons enrollees can connect with a board-certified provider for virtual urgent care, i.e., a telehealth visit. All virtual visits are available on-demand 24 hours a day, seven days a week, or by scheduled appointment with MDLive.

Visits are convenient, private and secure by mobile app, video or phone. Virtual visits avoid high-cost ERs and urgent care facilities. All prescriptions can be sent directly to a local pharmacy if medically necessary.

MDLive scope of services:
- Urgent care services for nonemergency needs, 24 hours a day, seven days a week
- Medical evaluation and management
- Virtual urgent care for common conditions: minor headache, minor sprain, nausea, vomiting, diarrhea, bumps, scrapes, cough, sore throat, congestion and respiratory issues

Provider types (all board-certified):
- Internal medicine
- Family practice

## Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

EPSDT is a federally mandated program developed for Medicaid recipients from birth through the end of their 21st birth month. All Humana Healthy Horizons enrollees within this age range should receive age-recommended EPSDT preventive exams, health screens and EPSDT special services needed to address health issues as soon as identified or suspected. EPSDT benefits are available at no cost to enrollees.

**EPSDT preventive services**
The EPSDT program is designed to provide comprehensive preventive healthcare services at regular age intervals. Regular EPSDT preventive visits find health issues early (including physical health, mental health, and growth and developmental health) so additional testing, evaluation or treatment can start right away. EPSDT preventive services are available at the recommended ages and at other times when needed.

EPSDT stresses health education to children and their caretakers related to early intervention; health and safety risk assessments at every age; referrals for further diagnosis and treatment of problems discovered during exams; and ongoing health maintenance. Covered services and EPSDT preventive exam components include:
- Comprehensive health and development history
- Comprehensive unclothed physical examination
- Laboratory tests, including (where indicated) blood-lead level screening/testing, anemia test using hematocrit or hemoglobin determinations, sickle cell test, complete urinalysis, testing for sexually transmitted diseases, tuberculin test, and pelvic examination
- Developmental screening/surveillance, including autism screening
- Sensory screenings and referrals for vision and hearing
- Nutritional assessment, including body mass index (BMI) and blood pressure
- Dental screenings and referrals to a dentist, as indicated (dental referrals are recommended to begin during a child's first year of life and are required at 2 years and older)
- Psychological/behavioral assessments, SUD assessments and depression screenings
- Assessment of immunization status and administration of required vaccines

- Health education and anticipatory guidance (e.g., age-appropriate development, healthy lifestyles, accident and disease prevention, at-risk and risk behaviors, and safety)
- Referral for further evaluation, diagnosis and treatment
- Routine screening for postpartum depression should be integrated into well-child visits at 1, 2, 5 and 6 months

**EPSDT special services**

Under the EPSDT benefit, Medicaid provides comprehensive coverage for any service described in section 1905(a) of the Social Security Act. EPSDT special services include coverage for other medically necessary healthcare, evaluation, diagnostic services, preventive services, rehabilitative services and treatment or other measures not covered under Kentucky Medicaid.

Special services included in the EPSDT benefit may be preventive, diagnostic or rehabilitative treatment or services that are medically necessary to correct or ameliorate the individual's physical, developmental or behavioral condition.

Medically necessary services are available regardless of whether those services are covered by Kentucky Medicaid. Medical necessity is determined on a case-by-case basis. EPSDT special services subject to medical necessity often require prior authorization.

Consideration must be given to the child's long-term needs, not only immediate needs, and must consider all aspects of the child's health, such as physical, developmental, behavioral, etc.

**EPSDT exam frequency**

The Humana Healthy Horizons EPSDT Periodicity Schedule is updated frequently to reflect current recommendations of the American Academy of Pediatrics (AAP) and Bright Futures.

Schedule updates are available via **AAP**.

| | | |
|---|---|---|
| **Infancy** | | |
| Younger than 1 month | 2 months | 4 months |
| 6 months | 9 months | 12 months |
| **Early childhood** | | |
| 15 months | 18 months | 24 months |
| 30 months | 3 years | 4 years |
| **Middle childhood** | | |
| 5-10 years | | |
| **Adolescence and young adults** | | |
| 11-20 years | | |
| 21 years (through the end of the enrollee's 21st birth month) | | |

**Child blood-lead screenings**

The Kentucky Medicaid Department for Public Health Childhood Lead Poisoning Prevention Program (CLPPP) requires that children receive a blood-lead level test at 1 and 2 years. Federal regulation requires that all children receive a blood test for lead at:

- 12 months and 24 months
- 36 months and 72 months for children who have not had a previous blood lead screening

This is a required part of the EPSDT exam provided at these ages.

**Lead screening test specifications**

- Kentucky Medicaid requires healthcare providers to provide blood-lead screening at 12 months and 24 months.
- Children 6 months to 6 years, per the AAP: The Centers for Medicare & Medicaid Services (CMS) requires each state to use a periodicity schedule to provide EPSDT services at age-recommended intervals that meet reasonable standards of medical practice. Kentucky uses the periodicity schedule published by the AAP and Bright Futures; 907 KAR 11:034.

- All children 72 months and younger and pregnant women who, per KRS 211.900:
  - Reside in dwellings or dwelling units which were constructed and painted prior to 1978
  - Reside in geographic areas defined by the Kentucky Cabinet for Health and Family Services (CHSF) as high risk
  - Possess one or more risk factors identified in a lead poisoning verbal risk assessment approved by Kentucky CHSF

Taking Centers for Disease Control and Prevention (CDC) guidelines and recommendations into account as well as Kentucky laws, children or pregnant women with confirmed elevated blood-lead levels greater than 5 µg/dL will be provided case management services by the local health department. Children and pregnant women with a confirmed blood-lead level greater than 15 µg/dL require public health environmental action per KRS 211.905 and a comprehensive environmental lead home inspection/risk assessment.

## Immunizations

Immunizations are an important part of preventive care for children and should be administered during well-child/EPSDT exams as needed. Humana Healthy Horizons endorses the same recommended childhood immunization schedule recommended by the CDC and approved by the Advisory Committee on Immunization Practices (ACIP), the AAP, and the American Academy of Family Physicians (AAFP). This schedule is updated annually and current updates can be found on the **AAP website**.

## Vaccines for Children program

The Kentucky Department of Public Health and the Kentucky DMS Vaccines for Children (VFC) program offers certain vaccines free of charge to Medicaid enrollees younger than 21.

When administering VFC vaccines, providers should never bill two different payers (for example: bill a patient's Medicaid and private insurance) for the same vaccine administration fee. For Medicaid-eligible children, Medicaid should be billed the vaccination administration fee.

VFC providers are required to maintain immunization records that include:

- Name of the vaccine administered
- Date vaccine was administered
- Date vaccine information statements (VIS) were given
- Publication date of VIS
- Name of vaccine manufacturer
- Lot number
- Name and title of person who administered the vaccine
- Address of clinic where vaccine was administered

VFC providers are required to distribute a current VIS each time a vaccine is administered and maintain records in accordance with the national Childhood Vaccine Injury Act, which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System.

VFC providers are required to maintain all records related to the VFC program for a minimum of three years (or longer if required by state law) and, on request, make these records available for review.

VFC records include VFC screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.

VFC providers must retain and implement a vaccine management plan for routine and emergency vaccine management.

Humana Healthy Horizons requests network providers notify Provider Relations upon enrollment as a VFC provider. Email notification to **KYMCDPR@humana.com** should include National Provider Identifier/Tax ID Number (NPI/TIN) and locations.

Additional information on the Vaccines for Children program is **available online**.

## Services not covered

Humana Healthy Horizons must provide covered services under current administrative regulations. The scope of services may be expanded with approval of the Kentucky DMS and as necessary to comply with federal mandates and state laws. Certain Medicaid services are currently excluded from the Humana Healthy Horizons benefits package but continue to be covered through the traditional fee-for-service Medicaid program. Humana Healthy Horizons is familiar with these

excluded services, designated Medicaid "wrap-around" services, and coordinates with Kentucky DMS providers in the delivery of these services to enrollees.

Humana Healthy Horizons may access information relating to these excluded service programs from Kentucky DMS to aid in the coordination of services.

Under federal law, Medicaid does not receive federal matching funds for certain services. Some of these excluded services are optional services that Kentucky DMS may or may not elect to cover. Humana Healthy Horizons is not required to cover services that Kentucky DMS elects not to cover for enrollees.

The following services currently are not covered by the Kentucky Medicaid program:

- All laboratory services performed by a provider without current certification, in accordance with the Clinical Laboratory Improvement Amendment (CLIA) (Please note: This requirement applies to all facilities and individual providers of any laboratory service.)
- Cosmetic procedures or services performed solely to improve appearance
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only
- Medical or surgical treatment of infertility (e.g., the reversal of sterilization, in-vitro fertilization, etc.)
- Induced abortion and miscarriage performed out-of-compliance with federal and Kentucky laws and judicial opinions
- Paternity testing
- Personal service or comfort items
- Post-mortem services
- Services including drugs that are investigational and mainly for research purposes or experimental in nature
- Sex transformation services
- Sterilization of a mentally incompetent or institutionalized enrollee
- Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky CHFS
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid program regulations referenced herein
- Services for which the enrollee has no obligation to pay and for which no other person has a legal obligation to pay

**Out-of-network care for services not available**

Humana Healthy Horizons arranges for out-of-network care when an in-network provider is unable to provide enrollees with necessary covered services. This includes second opinions related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. Humana Healthy Horizons coordinates payment with the out-of-network provider to ensure the cost to the enrollee is not greater than it would be if the service were provided in-network. Please see copayment section.

If medical care is needed from a medical facility outside the enrollee's service area (defined as the enrollee's residential county and the counties next to it), a note from the PCP is required explaining the reason for traveling outside the service area to receive services.

## Value-added services

Humana Healthy Horizons offers enrollees extra benefits, tools and services (at no cost to the enrollee) that are not otherwise covered or that exceed limits outlined in the Kentucky State Plan and the Kentucky Medicaid Fee Schedules.

These added benefits are in excess of the amount, duration and scope of covered services listed in this manual.

In instances where an added benefit is also a Medicaid-covered service, Humana Healthy Horizons administers the benefit in accordance with all applicable service standards pursuant to our contract, the Kentucky Medicaid State Plan and all Medicaid Coverage and Limitations handbooks.

Humana Healthy Horizons enrollees have specific enhanced benefits:

| Value-added service | Details and limitations |
|---|---|
| **Baby and Me meals** | Up to two pre-cooked, home-delivered meals per day are provided for 10 weeks for pregnant women who are high risk.<br><br>Care manager approval required. |
| **Convertible car seat or portable crib** | Pregnant enrollees who enroll and actively participate in our HumanaBeginnings® care management program and complete a comprehensive assessment and at least one follow-up call with a HumanaBeginnings care manager can select one convertible car seat or portable crib per infant, per pregnancy. |
| **Criminal expungement services** | For enrollees 18 and older, reimbursement of up to $340 for criminal record expungement, as allowed per KYCourts.gov, per lifetime, is provided. |
| **Disaster preparedness meals** | One box of 14 shelf-stable meals before or after a natural disaster is provided twice per year. The enrollee must not live in a residential or nursing facility. The governor must declare the disaster for the enrollee to be eligible for the meals. |
| **Doula services*** | Doula assistance is provided for pregnant females to provide emotional and physical support to the laboring mother and her family. Five prenatal visits, three postpartum visits and one visit for delivery assistance per pregnancy are provided. |
| **Fresh produce box** | Up to four boxes of in-season, nutritious fresh fruits and vegetables are provided annually for enrollees under care management for diabetes or heart conditions.<br><br>Care manager approval required. |
| **General Education Development (GED) testing** | For enrollees 18 and older, GED test preparation assistance, including a bilingual advisor, access to guidance and study materials, and unlimited use of practice tests are provided. Test preparation assistance is provided virtually to allow maximum flexibility for enrollees. This benefit also includes test-pass guarantee to provide enrollees multiple attempts at passing the test. |
| **Haircuts for Kids** | One standard haircut, valued at $20, for enrollees in grades K-12 who upload a photo of their school registration form, school ID or class schedule is provided. The redemption period is for March 2024 through April 2024.<br><br>One standard haircut, valued at $20, for enrollees in grades K-12 who upload a photo of their school registration form, school ID or class schedule is provided. The redemption period is July 2024 through Sept. 2024.<br><br>Enrollees may redeem this reward through the Go365 mobile app by uploading a photo of their school registration form, school ID or class schedule. |
| **Housing assistance** | For enrollees 18 and older, up to $500 per enrollee per year (unused allowance does not roll over to the next year) is provided to assist with the following housing expenses:<br>• Apartment rent or mortgage payment (late payment notice required)<br>• Utility payment for electric, water, gas or internet (late payment notice required)<br>• Trailer park and lot rent if this is the enrollee's permanent residence (late payment notice required)<br>• Moving expenses via licensed moving company when transitioning from a public housing authority<br><br>Plan approval is required.<br>• The enrollee must not live in a residential facility or nursing facility.<br>• Funds will not be paid directly to the enrollee.<br><br>If the bill is in the spouse's name, a marriage certificate may be submitted as proof. |

| Value-added service | Details and limitations |
|---|---|
| **Post-discharge meal** | 10 refrigerated home-delivered meals following discharge from an inpatient or residential facility are provided. This benefit is limited to four discharges per year. |
| **Self-monitoring devices—blood pressure kit** | Enrollees 21 and older under care management may receive one digital blood pressure kit once every three years. The kit includes the cuff and monitor.<br><br>Care manager approval is required. |
| **Self-monitoring devices—weight scale** | Enrollees 21 and older under care management may receive one weight scale every three years.<br><br>Care manager approval is required. |
| **Smartphone app for diabetes management** | For enrollees 18 and older with type 2 diabetes, who are not already receiving care management services, unlimited access to an innovative digital therapeutic smartphone app (Vida Health) for diabetes management is provided. |
| **Smartphone services** | One free smartphone is provided through the federal Lifeline program, per household. Enrollees who are younger than 18 will need a parent or guardian to sign up.<br><br>This benefit covers, per lifetime: one phone; one charger; one set of instructions; unlimited talk, text and high-speed data; training for the enrollee and their caregiver at the first case manager orientation visit if the enrollee is enrolled in care management. This benefit includes calls to Canada and Mexico.<br><br>The enrollee must make one phone call or send one text message every month to keep the benefit.<br><br>The enrollee may qualify for enhanced benefits through the Affordable Connectivity Program, which provides unlimited minutes, a 10 GB hotspot and unlimited data. Enrollees can opt in to this benefit by calling SafeLink at **800-SAFELINK** (**800-723-3546**) or online at http://www.safelink.com/en/ACP11.<br><br>Benefits are subject to change by the Federal Communications Commission under the Lifeline program. |
| **Sports physical*** | One sports physical per year is provided for enrollees ages 6 to 18. |
| **Tobacco and vaping cessation coaching** | Tobacco and vaping cessation coaching focuses on coaching for enrollees ages 12 and older. The program is designed as a six-month engagement for a total of eight coaching calls, but enrollees have 12 months to complete the program if needed.<br><br>Humana Healthy Horizons' tobacco and vaping cessation health coaching program offers support for both OTC and prescription nicotine replacement therapy. |
| **Weight management coaching** | Weight management coaching delivers weight management intervention for enrollees who are 12 years and older. Upon receiving provider clearance, the enrollee can complete six weight management coaching sessions with a health coach, approximately one call per month for a period of six months. |
| **Workforce development program** | For enrollees 18 and older, up to 12 months of assistance is provided to support each participant in planning for the future (e.g., education, training, financial counseling) and engaging in and maintaining meaningful work (e.g., job support and retention coaching); and three round-trip bus vouchers for transportation when enrolled in the program where available.<br><br>Enrollee reimbursement is provided for childcare of $40 maximum per quarter, up to four times per year, for caretakers seeking job opportunities. The enrollee must participate in the Humana Workforce Development program in order to be eligible for reimbursement consideration. |

* Humana Healthy Horizons publishes billing guidelines for these services.

## Direct access

Humana Healthy Horizons makes covered services available and accessible to enrollees as specified by Kentucky DMS, in accordance with 42 C.F.R. 438 and applicable state statutes and regulations.

Humana Healthy Horizons routinely evaluates out-of-network utilization and contacts high-volume providers to determine if they are qualified and interested in enrolling in Humana Healthy Horizons' network. If so, Humana Healthy Horizons enrolls the provider as soon as the necessary procedures are completed.

When an enrollee wishes to receive a direct-access service or receives a direct-access service from an out-of-network provider, Humana Healthy Horizons contacts the provider to determine if they are qualified for and interested in enrolling in the network. If so, Humana Healthy Horizons enrolls the provider as soon as the necessary enrollment procedures have been completed.

Humana Healthy Horizons ensures direct access and may not restrict an enrollee's choice of a qualified provider for the following services within the network:

- Primary care vision services, including the fitting of eye glasses, provided by ophthalmologists, optometrists and opticians
- Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists
- Voluntary family planning in accordance with federal and state laws and judicial opinion
- Maternity care for enrollees younger than 18
- Immunizations to enrollees younger than 21
- Sexually transmitted disease screening, evaluation and treatment
- Tuberculosis screening, evaluation and treatment
- Testing for HIV, HIV-related conditions and other communicable diseases as defined by 902 KAR 2:020
- Chiropractic services
- For enrollees with special healthcare needs determined through an assessment in need of a course of treatment or regular care monitoring, a specialist as appropriate for the enrollee's condition and identified needs
- Women's health specialists

## Pharmacy

The drug benefit is provided by MedImpact and Kentucky Medicaid. Humana Healthy Horizons works with pharmacy benefit manager (PBM), MedImpact Healthcare Systems Inc., which serves all providers in managed care.

The MedImpact website has answers to many questions providers may have about the pharmacy benefit. MedImpact's website can be accessed through a desktop computer or mobile device. When providers visit **https://kyportal.Medimpact.com**, a welcome page for Kentucky DMS hosted by MedImpact will display. Providers can select the provider portal at the top of the page. This allows providers to select the Resources tab at the top of the page. The Resources tab provides downloadable documents, including the Preferred Drug List (PDL), OTC Drug List, PA Criteria and Diabetic Supplies Preferred Drug List.

The Tools tab allows providers to check drug coverage quickly and find a pharmacy in the enrollee's area that accepts Medicaid. The Contact tab is where providers can find important phone numbers to talk with someone about medical questions or MedImpact about pharmacy questions or concerns.

Humana Healthy Horizons recommends that providers take a few minutes to review the MedImpact website to familiarize themselves with the pharmacy benefit information provided. For questions about the MedImpact website or pharmacy benefit, MedImpact is available 24 hours a day, seven days a week by calling **800-210-7628**.

**Medications administered in the provider setting**

Humana Healthy Horizons covers medications administered in a provider setting, such as a provider's office, hospital outpatient department, clinic, dialysis center or infusion center. PA requirements exist for many injectables. Medicaid providers may:

- Obtain forms at **Humana.com/medPA**
- Fax requests to **888-447-3430**
- View **preauthorization and notification lists**

**Pharmacy Lock-in Program**

The Lock-in Program is designed for individuals receiving Medicaid in Kentucky who need help managing their use of prescription medications. It is intended to limit overuse of benefits and reduce unnecessary costs to Medicaid while providing an appropriate level of care for the enrollee. Humana Healthy Horizons enrollees who meet the program criteria will be locked in to one pharmacy. The Lock-in Program is required by Kentucky DMS.

Humana Healthy Horizons monitors claim activity for signs of misuse or abuse in accordance with state and federal laws. If a review of an enrollee's claim activity reveals a health and safety concern with the number and type of controlled substance prescriptions or misuse of prescriptions, the enrollee is considered a candidate for the Lock-in Program.

Enrollees identified to be enrolled in the Lock-in Program receive written notification from Humana Healthy Horizons, along with the designated Lock-in pharmacy's information and the enrollee's right to appeal the decision.

Enrollees are initially locked-in for a total of 12 months, during which the enrollee can only request a change from their designated Lock-in provider once. Once the 12-month lock-in period expires, the lock is released for six months. A utilization review is then completed to determine if the enrollee would benefit from continuing in the Lock-in Program. If the decision is made to continue, the new lock-in period is in place for 24 months.

**Referrals**

Humana Healthy Horizons monitors enrollees' claim history and utilization to identify enrollees who may benefit from enrollment in the pharmacy Lock-in Program. Enrollees also may be referred for evaluation to participate in the Lock-in Program by their PCP or a specialist by calling **855-330-8054**. Excluded from enrollment in the Lock-in Program are enrollees who are:

- Diagnosed with sickle cell disease or cancer
- Residing in institutionalized settings (e.g., nursing facilities)
- Dual-enrolled in Medicare and Medicaid
- Identified participating in the Guardianship program

## Utilization management

Utilization management (UM) helps maintain the quality and appropriateness of healthcare services provided to Humana Healthy Horizons enrollees. Utilization review determinations are based only on appropriateness of care and service and existence of coverage. Humana Healthy Horizons does not reward providers or staff for denying coverage or services. There are no financial incentives for Humana Healthy Horizons staff to encourage decisions that result in underutilization. Humana Healthy Horizons does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition. Humana Healthy Horizons establishes measures designed to maintain quality of services and control costs that are consistent with our responsibility to our enrollees; places appropriate limits on a service on the basis of criteria applied under the Medicaid state plan and applicable regulations, such as medical necessity; and places appropriate limits on a service for utilization control, provided the service furnished can reasonably be expected to achieve its purpose. Services supporting individuals with ongoing or chronic conditions or who require long-term services and support are authorized in a manner that reflects the enrollee's ongoing need for such services and support. The UM department performs all UM activities, including PA, concurrent review and discharge planning. Humana Healthy Horizons monitors inpatient and outpatient admissions and procedures to ensure appropriate medical care is rendered in the most appropriate setting, using the most appropriate resources. Humana Healthy Horizons also monitors the coordination of medical care to ensure its continuity. Referrals to the Humana Healthy Horizons Care Management team are made, if needed.

Humana Healthy Horizons completes an annual assessment of satisfaction with the UM process, identifying areas for improvement.

**UM criteria**

Humana Healthy Horizons utilizes nationally recognized criteria to determine medical necessity and appropriateness of inpatient acute, behavioral health, rehabilitation and skilled nursing facility admissions. These criteria are designed to assist providers in identifying the most efficient quality care practices in use today. They are not intended to serve as a set of rules or a replacement for a provider's medical judgment about individual patients.

Humana Healthy Horizons defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. Humana Healthy Horizons also has policy statements developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria for approval, the case is forwarded to a medical director for further review and determination.

**Access to UM staff**

Providers may send an email to the UM staff with any UM questions.

- Medical health inquiries: **KYMCDMedicalUM@humana.com**
- Behavioral health inquiries: **KYMCDBehavioralHealthUM@humana.com**

Please keep the following in mind when contacting UM staff:

- Staff are available Monday through Friday, 8 a.m. to 6 p.m., Eastern time.
- Staff can receive inbound communications regarding UM issues after normal business hours.
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff are available to respond to email inquiries regarding UM issues.
- Staff are accessible to answer questions about the UM process.
- In the best interest of Humana Healthy Horizons enrollees and to promote positive healthcare outcomes, Humana Healthy Horizons supports and encourages continuity of care and coordination of care between medical providers as well as between behavioral health providers.

Enrollee health is always Humana Healthy Horizons' number one priority. Provider reviewers from Humana Healthy Horizons are available to discuss individual cases with attending providers on request. Clinical criteria and clinical rationale or criteria used in making UM determinations are available on request by email to one of the following UM departments:

- For medical health inquiries: **KYMCDMedicalUM@humana.com**
- For behavioral health inquiries: **KYMCDBehavioralHealthUM@humana.com**

On request and at no cost to the provider, Humana Healthy Horizons supplies all documents, records and other information relevant to an adverse payment or coverage determination. If you want to request a peer-to-peer discussion on an adverse determination with a Humana Healthy Horizons provider reviewer, please send an email to the addresses above within five business days of the determination.

## Referrals and prior authorizations

**Referrals**

See Value-Added Service section of this manual for details.

Humana Healthy Horizons enrollees may see any participating provider within our network, including specialists and inpatient hospitals. Enrollees may self-refer to any participating provider. PCPs do not need to arrange or approve these services for enrollees as long as applicable benefit limits have not been exhausted. Exceptions to this policy apply to enrollees who have been designated to participate in the pharmacy Lock-in Program. Please refer to the Lock-in Program section of this manual.

For a listing of direct access provider specialties, please refer to the Direct Access section of this manual. If an enrollee requires medically necessary services from a nonparticipating provider, the provider may need to call to obtain PA.

**Second opinions for nonparticipating providers**

Although Humana Healthy Horizons does not require referrals, an enrollee may receive a second opinion. Providers or enrollees may request a second opinion at equal cost to the enrollee if the service was obtained in network.

The following criteria should be used when selecting a provider for a second opinion:

- The provider must be enrolled with Kentucky DMS.
- The provider must be a participating provider. If not, PA must be obtained to send the patient to a nonparticipating provider. The provider must not be affiliated with the enrollee's PCP or the specialist practice group from which the first opinion was obtained.
- The provider must be in an appropriate specialty area.

- Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

**Release due to ethical reasons**

Providers are not required to perform any treatment or procedure that is contrary to the provider's conscience, religious beliefs or ethical principles, in accordance with 42 C.F.R 438.102. Please refer to the Involuntary Dismissal section of this manual for specific procedural requirements.

**Prior authorization**

When PA is requested for a service rendered in the same month, enrollee eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent on enrollee eligibility on the date of service. Providers must verify eligibility on the date the service is to be rendered. Humana Healthy Horizons is not able to pay claims for services provided to ineligible enrollees. It is important to request PA as soon as it is known that a service is needed.

All services that require PA from Humana Healthy Horizons should be authorized before the service is delivered. Humana Healthy Horizons is not able to pay claims for services in which PA is required but not obtained by the provider. Visit **Availity Essentials** for PA status. For adverse benefit determinations, Humana Healthy Horizons will notify the enrollee by letter with a copy to you at the address on file.

For standard PA decisions, Humana Healthy Horizons provides notice to the provider as expeditiously as the enrollee's health condition requires, but no later than two business days following authorization request date. The time frame for a standard authorization request may be extended up to 14 days if the provider or enrollee requests an extension, or if Humana Healthy Horizons justifies, in writing, to Kentucky DMS a need for additional information and how the extension is in the enrollee's best interest. For cases in which a provider indicates, or Humana Healthy Horizons determines, that following the standard time frame could seriously jeopardize the enrollee's life, health, or ability to attain, maintain or regain maximum function, Humana Healthy Horizons will complete an expedited authorization decision within 24 hours and provide notice as expeditiously as the enrollee's health condition requires. Please specify in Availity Essentials or on the authorization fax request cover if you believe the request needs to be expedited.

**Medicaid services that require prior authorization**

Healthcare providers should review the **Kentucky Medicaid Prior Authorization List**.

**Requesting prior authorization**

This section describes how to request PA for medical and behavioral health services. For pharmacy, please refer to the Pharmacy section of this manual. A **list of contracted vendors who handle certain authorization types** is available online. As submission of such authorizations may vary from our regular processes, Humana Healthy Horizons asks that you check this page prior to submitting an authorization.

**Medical and behavioral health**

PA for healthcare services can be obtained by contacting the UM department online or via email, fax, phone or mail:

- Visit **Availity Essentials**
- Access various **prior authorization forms online**
- Email completed forms to **CorporateMedicaidCIT@Humana.com**
- Fax completed PA forms to **833-974-0059** or call **800-444-9137**

When requesting authorization, please provide the following information:

- Enrollee/patient name and Humana Healthy Horizons enrollee ID number
- Provider name, NPI and TIN for ordering/servicing providers and facilities
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-network provider, if applicable

- Clinical information to support the medical necessity of the service:
  - If the request is for inpatient admission for elective, urgent or emergency care, please include admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.
  - If inpatient surgery is planned, please include the date of surgery, surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, all appropriate clinical review and anticipated discharge needs.
  - If the request is for outpatient surgery, please include the date of surgery, surgeon and facility, diagnosis and procedure planned and anticipated discharge needs.

**Prior authorization partners**

Humana Healthy Horizons partners with WholeHealth Living® (a brand of Tivity Health), EviCore healthcare, Avesis and Evolent Health (formerly New Century Health) for PA reviews. For the latest information on submitting authorization requests to these partners and others, please visit **Humana.com/PAL** or visit the Provider Prior Authorization details on **Humana.com/HealthyKY**.

**EviCore healthcare**

Humana Healthy Horizons and EviCore healthcare partner to provide authorization services for Kentucky Medicaid beneficiaries for the following services:

- 3D rendering
- Computed tomography angiography (CTA)
- Computerized tomography (CT) scan
- Magnetic resonance angiography (MRA)
- Magnetic resonance imaging (MRI)
- Nuclear medicine
- Positron emission tomography (PET)
- Single-photon emission computerized tomography (SPECT) scan
- Physical therapy
- Occupational therapy
- Speech therapy

Submit authorization requests to EviCore:

- By **visiting online**, opens new window (registration required)
- By calling **866-672-8115**, Monday through Friday, 7 a.m. to 7 p.m., Eastern time
- By faxing your request to **800-540-2406** (Advanced Imaging Services)
- By faxing your request to **855-774-1319** (Physical therapy/occupational therapy/speech therapy)

**WholeHealth Living (a brand of Tivity Health)**

For all chiropractic services on the Kentucky DMS fee schedule, you must get PA through WholeHealth Living. To submit a PA request to Tivity for chiropractic services:

- Use the **online portal**
- Call **855-800-9804**, Monday through Friday, 8:30 a.m. to 5:30 p.m., Eastern time
- Fax **888-492-1025**

**Avēsis**

For authorizations related to dental and vision services, Humana Healthy Horizons partners with Avēsis.

- Dental: Call **888-211-0599**
- Vision: Call **844-511-5760**

Contact information for the single PBM, MedImpact, is located in the Pharmacy section of this manual.

**Chemotherapy**

For adults 18 and older, Humana Healthy Horizons partners with Evolent for chemotherapy agents and supportive and symptom management drug PA requests. Choose from the following options to submit a request for PA to Evolent:

- A **list of applicable drugs** is available online.
  - This list is subject to change with notification. However, this list may be modified throughout the year without notification via U.S. postal mail for additions of new-to-market medications or step-therapy requirements for medications.

- To initiate an online PA request, sign in to **Evolent's website**. Enter your username and password. If you have not yet received a username and password, please call Evolent at **855-427-1372** and select option 1.
- To submit a request by phone, please call Evolent's intake coordinator department at **855-427-1372** and select option 1 Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

Authorization is not a guarantee of payment. Authorization is based on medical necessity and is contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Administrative denials may be rendered when applicable authorization procedures are not followed. Enrollees cannot be billed for services that are administratively denied due to a provider not following the requirements listed in this manual.

## Retrospective review

A retrospective review is a request for a review for authorization of care, a service or a benefit for which an authorization is required but not obtained before the delivery of the care, service or benefit. Humana Healthy Horizons requires PA to ensure covered patients receive medically necessary and appropriate services. Claims not meeting the necessary criteria as described below will be administratively denied.

On request, Humana Healthy Horizons only allows for a retrospective authorization submission after the date of service when a PA is required but not obtained in the following circumstances:

- The service is directly related to another service for which prior approval was obtained, and the service was already performed.
- The new service was not needed at the time the original prior-authorized service was performed.
- The need for the new service was determined at the performance of the original prior-authorized service.
- A Humana Healthy Horizons-covered patient is determined to be retroactively eligible for Medicaid. (Retroactive Medicaid coverage is defined as a period of time up to three months prior to the application month.)

Exception: A PA obtained prior to an enrollee transitioning from another MCO to Humana Healthy Horizons will be upheld for 90 days following the transition.

Providers have 90 calendar days from the following events to request retrospective review:

- The date of service
- The inpatient discharge date
- The initial date of a service when the service spans several months
- The date of the primary insurance carrier's EOP or authorization denial that demonstrates service was not a covered service

Requests for retrospective review that exceed this 90-calendar-day time frame will be denied.

**Exception to the above criteria:** For enrollee retrospective eligibility, healthcare providers have up to 30 calendar days from the Kentucky Medicaid Management Information System Added Date to submit a retrospective authorization request. For provider enrollment on a retrospective basis with Kentucky DMS, retroactive Medicaid eligibility will be honored for 30 days from published date.

When submitting a retroactive authorization request, please include the following documentation:

- Patient name and Humana Healthy Horizons ID number
- Authorization number of the previously authorized service for the related request
- Clinical information supporting the service

A retrospective review request for inpatient and outpatient services can be submitted via:

- **Availity Essentials**
- Phone/interactive voice response **800-444-9137**
- Fax **833-974-0059**

For requests submitted via Availity Essentials or by fax, the provider can check the status online on Availity Essentials. Providers can see the authorization status along with the authorization number associated with the request. Some outpatient authorization requests may auto-approve if the procedure code is not listed on our preauthorization list (PAL).

Humana Healthy Horizons' PAL is available online at **Humana.com/PAL**. Written notification for approved service requests is not provided unless requested. Requests for written notification can be included when clinical information is submitted or by calling **800-444-9137**.

Exceptions to this policy apply to enrollees in the pharmacy Lock-in Program.

More details regarding authorization inquiries for our EviCore, WholeHealth Living (a brand of Tivity Health) and Avēsis partners are available within other sections of this manual.

## Obtaining an authorization to a nonparticipating provider

Authorization is required for enrollees to be evaluated or treated by nonparticipating providers. All providers (referring, treating, nonparticipating) must be enrolled with Kentucky DMS as Kentucky Medicaid-enrolled providers to receive payment for services rendered to a Kentucky Medicaid recipient. Please refer to Prior Authorization Guidance issued by Kentucky DMS to find out about circumstances in which PA requirements may be waived due to public health emergencies.

## Claims

Humana Healthy Horizons follows the claims reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. It is critical that all provider addresses and phone numbers on file with Humana Healthy Horizons are up to date to ensure timely claims processing and payment delivery.

Please note: Failure to include International Classification of Diseases, Tenth Revision (ICD-10) codes on electronic or paper claims will result in claim denial.

**Claim submissions**

Claims must be submitted within 365 calendar days of the date of service or discharge. We do not pay claims with incomplete, incorrect or unclear information. Providers have 365 calendar days from the date of service or discharge to submit a corrected claim. The provider has 60 calendar days from the date of original claim submission denial to file a claim appeal. Humana Healthy Horizons accepts electronic and paper claims. We encourage you to submit routine claims electronically to take advantage of the following benefits:

- Faster claims processing
- Reduced administrative costs
- Reduced probability of errors or missing information
- Faster feedback on claims status
- Minimal staff training and cost

All claims (electronic and paper) must include the following information:

- Patient (enrollee) name
- Patient address
- Insured's Humana Healthy Horizons ID number: Be sure to provide the complete Humana Healthy Horizons enrollee ID for the patient.
- Patient's birth date: Always include the enrollee's date of birth so the correct enrollee can be identified (there may be more than one enrollee with the same name).
- Place of service: Use standard CMS location codes.
- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis code(s)
- HIPAA-compliant Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code(s) and modifiers when modifiers are applicable
- Units, where applicable (Anesthesia claims require number of minutes.)
- Date of service: Please include dates for each individual service rendered; date ranges are not accepted, even though some claim forms contain from/to formats. Please enter each date individually.
- PA number, when applicable: A number is needed to match the claim to the corresponding PA information. This is only needed if the service provided requires PA.
- NPI: Please refer to the Location of Provider NPI, TIN and Enrollee ID Number section of this manual
- Federal TIN or provider Social Security number: Every provider practice (e.g., legal business entity) has a different TIN.
- Billing and rendering taxonomy codes that match the Kentucky DMS Master Provider List (MPL)

- Billing and rendering addresses that match the Kentucky DMS MPL
- Signature of provider or supplier: The provider's complete name should be included. If Humana Healthy Horizons already has the provider's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

**Clearinghouse rejections**

When an electronic claim has been submitted to Humana Healthy Horizons, a series of edits trigger to determine the accuracy and completeness of the claims data. If a rejection is issued by Humana Healthy Horizons' clearinghouse, Availity Essentials, a message is returned that details the reason for the rejection. It is expected that corrections will be made to the electronic claim to ensure its eventual acceptance by Availity Essentials. If questions still exist on the rejection, providers are encouraged to contact their respective **Provider Relations representatives**.

**Corrected claims submission**

When claims have updates or errors during the initial submission, corrected claims can be submitted via paper claim or electronically. Providers have 365 days from the date of service to submit a corrected claim.

Paper submission of corrected claim(s) should be marked "Corrected" when resubmitted. Please mail corrected claims to:

**Humana Healthy Horizons in Kentucky**
P.O. Box 14601
Lexington, KY 40512-4601

When submitting corrected claims electronically, please complete all fields as detailed in the Submitting Electronic Transactions section of this provider manual. In addition, please update LOOP 2300 – Claim information, in the CLM0503 field to a frequency of 7. Updating the frequency indicator allows Humana Healthy Horizons to identify the submission as a corrected claim.

**Resolution of payment errors**

Claims determined by Humana Healthy Horizons to have been incorrectly paid or denied and are within 24 months of Humana's claims adjudication date will be reprocessed.  Providers will not be required to resubmit the claim.

**Contracted rate dispute process**

Humana Healthy Horizons has established a formal contracted rate dispute process to ensure timely resolution of provider disputes. Providers who have a contract or letter of agreement with Humana Healthy Horizons to provide Medicaid services in Kentucky can utilize this contracted rate dispute process, pursuant to KRS 304.17A-708. This process grants an opportunity for providers to dispute errors in payment in which the insurer has not paid the claim according to the contracted rate. Contracted rate dispute documentation must be received by Humana Healthy Horizons within 24 months of the original claim adjudication date.

When submitting a contracted rate dispute, a completed **Humana Healthy Horizons Contracted Rate Dispute Form** is required.

The following items must be attached to the Contracted Rate Dispute Form:
- Explanation of Payment for the disputed claim(s)
- The contract provision that the provider believes was misapplied in paying the claim

Humana Healthy Horizons may reject a provider's contracted rate dispute submission if the contracted rate dispute:
- Is incomplete
- Is not submitted within the time frame specified above
- Does not meet all of the requirements, as specified above

**Submission process**

Contracted rate disputes for dental and vision providers should be submitted to Avēsis by mail, fax or email or via the **Avēsis provider portal**.

**Mail:**
**Avēsis Third-Party Administrators, Inc. LLC**
**Attn: Complaint Appeals and Grievances**
P.O. Box 38300
Phoenix, AZ 85069-8300
Fax: **855-691-3243**
Email: **ag@avesis.com**

For all other providers, please submit claim contracted rate disputes to Humana Healthy Horizons by mail or fax or via your secure Availity Essentials account:

**Mail:**
**Humana Healthy Horizons**
**Contracted Rate Disputes**
P.O. Box 14546
Lexington, KY 40512-4546
Fax: **800-949-2961**

Humana Healthy Horizons makes a determination and then mails the provider a dispute decision letter within 30 calendar days of receipt of a complete contracted rate dispute. Providers who disagree with the decision and who have not exhausted their appeal rights may request an appeal. Claim appeals must be received within 60 days of the original claim adjudication date. For more information about appeals, please see the Grievance and Appeals section of this manual.

**Medicaid Bypass List for Medicare Non-covered Codes**
The Kentucky DMS Medicaid Bypass List for Medicare Non-covered Codes is a list of bypass codes and modifiers for Medicaid noncovered services and provider types available in the Network Notices section of the **provider website.**

Kentucky DMS developed this list to allow providers to bill Medicaid MCOs directly without first billing Medicare for COB requirements. Medicare does not cover these codes, so Medicaid acts as primary payer.

Kentucky DMS lists are specific to provider type, claim type, procedure, revenue, diagnosis codes and date range. Claims submitted that do not meet all bypass requirements are denied when submitted without the Medicare Explanation of Medicare Benefits for appropriate coordination of benefits.

On receipt of Kentucky DMS updates to these lists, Humana Healthy Horizons will analyze the lists, initiate configuration and test the updates based on Kentucky DMS changes. All updates will be implemented and in effect 90 days from our receipt of notice from Kentucky DMS.

Humana Healthy Horizons will not perform claims adjustments for previously paid claims based on Kentucky DMS updates to the Medicaid bypass lists for Medicare noncovered codes having retroactive dates unless required by Kentucky DMS.

Copies of the bypass lists can be downloaded using these links (will open Excel files):
- Provider Type 30 **http://apps.humana.com/marketing/documents.asp?file=3967496**
- All Provider Types Except Provider Type 30 **http://apps.humana.com/marketing/documents.asp?file=3967548**

**Bypass List for Commercial Non-covered Codes**
Humana Healthy Horizons developed a centralized commercial insurance coding list for those specific procedure codes and modifiers typically deemed as not covered outside of Medicaid. This list allows providers to bill the KY Medicaid MCO for primary coverage without the need to provide evidence of commercial coverage on their claims. Kentucky healthcare providers must still bill the primary carrier as Kentucky Medicaid is the payer of last resort.

The referenced list is available on the **Humana Healthy Horizons provider web portal**. As a reminder, the process allows providers to bill directly to the Kentucky Medicaid MCO without submitting an EOB or a **Commercial Bypass Attestation Form** if only procedure codes or modifiers on the list are on the claim submitted. Otherwise, an EOB is still required.

Note: This bypass code list is effective for dates of service after May 1, 2023. This list is subject to change with advance notice.

Claims submitted must adhere to the Kentucky DMS billing instructions specific to each provider type and specialty. Claims received that do not meet billing requirements may be subject to denial when submitted without the EOB for appropriate coordination of benefits.

If you have questions, please call Provider Services at **800-444-9137** Monday through Friday, 8 a.m. to 6 p.m., Eastern time.

## Provider Payments

Humana Healthy Horizons utilizes three payment options for providers:

- Paper check and remittance
- EFT/ERA
- Virtual credit card (VCC) payments

Paper check and remittance is the default provider payment option for Humana Healthy Horizons. Providers may elect to participate in EFT/ERA. Humana Healthy Horizons selects providers utilizing paper checks and remittance to participate in VCC.

**Electronic funds transfer (EFT)/Electronic remittance advice (ERA)**

Electronic claims payment offers you several advantages over traditional paper checks:

- Faster payment processing
- Reduced manual processes
- Access to online or electronic remittance information
- Reduced risk of lost or stolen checks

With EFT, your Humana Healthy Horizons claim payments are deposited directly in the bank account(s) of your choice. You also are enrolled in ERA, which replaces the paper version of your explanation of remittance. Please note: Fees may be associated with electronic transactions.

Please check with your financial institution or merchant processor for specific rates related to EFT. Check with your clearinghouse for fees associated with ERA transactions.

**How to enroll in EFT/ERA payment**

Get paid faster and reduce administrative paperwork with EFT and ERA.

Providers can use Humana Healthy Horizons' ERA/EFT Enrollment tool on Availity Essentials to enroll. To access this tool:

1. Sign in to Availity Essentials (registration required).
2. From the Payer Spaces menu, select Humana Healthy Horizons in Kentucky.
3. From the Applications tab, select the ERA/EFT Enrollment app. (If you don't see the app, contact your Availity Essentials administrator to discuss your need for this tool.)

EFT payment transactions are reported with file format CCD+, which is the recommended industry standard for EFT payments. The CCD+ format is a National Automated Clearing House Association (ACH) corporate payment format with a single, 80-character addendum record capability. The addendum record is used by the originator to provide additional information about the payment to the recipient. This format is also referenced in the ERA (835 data file). Contact your financial institution if you would like to receive this information.

The ERA replaces the paper version of the explanation of reimbursement (EOR). Humana Healthy Horizons delivers 5010 835 versions of all ERA remittance files that are compliant with HIPAA. Humana Healthy Horizons utilizes Availity Essentials as the central gateway for delivery of 835 transactions. You can access your ERA through your clearinghouse or through the secure provider tools available in Availity Essentials, which opens a new window.

**Virtual credit card payments**

Humana Healthy Horizons teamed up with PNC Healthcare and ECHO Health, Inc. to pay claims to eligible healthcare providers via VCC. We will notify providers and organizations prior to their enrollment in virtual card payments, and participants may opt out of the program by calling ECHO Health at **888-483-9212**.

If you receive notification you've been entered into the VCC program and you prefer to enroll in ERA/EFT instead, please see the ERA/EFT enrollment information in the previous section. You must decline participation in the VCC program by calling ECHO Health as soon as possible after receiving your VCC program notification.

VCC program participants will receive payment notification via fax or mail. Each notification contains a 16-digit number and remittance information for the claim(s) being paid. Process the virtual card as you do other card payments, by entering the 16-digit number and the full amount of the payment into your credit/debit point-of-sale terminal. You will pay your standard merchant fees, which include banking loyalty fees and Humana Healthy Horizons revenue share payments. If you have questions about a VCC notification you received, wish to change your account setup or want to decline participation in the program, call ECHO Health's dedicated help center at **888-483-9212**, Monday through Friday, 8 a.m. to 6 p.m., Eastern time.

## Submitting electronic transactions

**Provider portal**

Humana Healthy Horizons partners with Availity Essentials to allow providers to reference enrollee and claim data for multiple payers using one login. Availity Essentials provides the following benefits:

- Eligibility and benefits
- Referrals and authorizations
- Claim status
- Claim submission with attachments
- Submission of disputes and appeals
- Remittance advice
- Claim accuracy and completeness issues

To learn more, call **800-282-4548** or visit Availity.com. For information regarding electronic claim submission:

- Email your local Provider Contracting representative at ProviderDevelopmentKYWV@humana.com
- Visit Humana.com/providers and choose Claims and Payments then Claims and encounter submission
- Visit the provider portal

**Electronic data interchange (EDI) clearinghouses**

EDI is the computer-to-computer exchange of business data in standardized formats. EDI transmissions must follow the transaction and code set format specifications required by HIPAA. Our EDI system complies with HIPAA standards for electronic claim submission.

To submit claims electronically, providers must work with an electronic claim clearinghouse. Humana Healthy Horizons currently accepts electronic claims from Kentucky providers through the clearinghouses listed below. Please contact the clearinghouse of your choice to begin electronic claim submission.

When filing an electronic claim, you will need to utilize one of the following payer IDs:

- 61101 for claims seeking payment under Humana Healthy Horizons
- 61102 for encounters by providers under a capitation agreement with Humana Healthy Horizons

Following is a list of some of the commonly used claims clearinghouses and phone numbers:

| | | |
|---|---|---|
| **Availity** | Availity.com | **800-282-4548** |
| **TriZetto** | trizettoprovider.com | **800-556-2231** |
| **McKesson** | Mckesson.com | **800-782-1334** |
| **Change Healthcare** | changehealthcare.com | **800-792-5256** |
| **SSI Group** | Thessigroup.com | **800-820-4774** |

**5010 transactions**

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic healthcare and pharmacy transactions. This action was taken in preparation to implement ICD-10 CM codes in 2015. The new standard is the HIPAA 5010 format. The following transactions are covered under the 5010 requirement:

- 837 claims encounters

- 276/277 claim status inquiry
- 835 electronic remittance advice
- 270/271 eligibility
- 278 PA requests
- 834 enrollment

## Procedure and diagnosis codes

HIPAA specifies that the healthcare industry use the following four code sets when submitting healthcare claims electronically:

- ICD-10-CM, available from the U.S. Government Printing Office by calling **202-512-1800**, or faxing **202-512-2250**. Also available from other vendors.
- **CPT**
- **HCPCS**
- **National Drug Codes (NDC)**

Please note: Humana Healthy Horizons also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plan organizations. Local or proprietary codes are no longer allowed.

**Unlisted CPT/HCPCS codes**

If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:

- A full, detailed description of the service provided
- A report, such as an operative report or a plan of treatment
- Other information that would assist in determining the service rendered

As an example, the CPT code 84999 is an unlisted lab code that requires additional explanation.

**National Provider Identifier (NPI), Tax Identification Number (TIN or tax ID) and taxonomy**
Your NPI and TIN are required on all claims, in addition to your provider taxonomy and specialty type codes (e.g., federally qualified health center, rural health center and/or primary care center) using the required claim type format (CMS-1500, UB-04 or Dental ADA) for the services rendered. Kentucky DMS requires all NPIs, billing and rendering addresses, and taxonomy codes be present on its Kentucky DMS MPL. Claims submitted without these numbers, or information that is not consistent with the Kentucky DMS MPL, are rejected. Please contact your EDI clearinghouse if you have questions on where to use the Tax ID or taxonomy numbers on the electronic claim form you submit.

Kentucky DMS has billing provider taxonomy claim requirements for the following provider types:

- Federally qualified health centers, provider type 31 with a specialty code 080
- Rural health centers, provider type 35

If billing providers have only one taxonomy linked to their NPI on the Kentucky DMS MPL, then their claims do not need to include taxonomy. Taxonomy is still required for the following:

- Billing providers who have multiple taxonomies linked to their NPI on the Kentucky DMS MPL
- All rendering providers

If your NPI and taxonomy codes change, please ensure you update your taxonomy information with Humana Healthy Horizons and the Kentucky DMS MPL.

Please call Humana Healthy Horizons Provider Services at **800-444-9137**, or your provider contracting representative, to update your demographic information. Please mail your changes to:
**Humana Provider Correspondence**
P.O. Box 14601
Lexington, KY 40512-4601

**Location of provider NPI, TIN and enrollee ID number**
Humana Healthy Horizons accepts electronic claims in the 837 ANSI ASC X12N (005010A1) file format for both professional and hospital claims.

On 5010 (837P) professional claims, the provider NPI should be in the following location:

- Medicaid: 2010AA Loop – Billing provider name
- 2010AA Loop – Billing provider name
- Identification code qualifier – NM108 = XX
- Identification code – NM109 = billing provider NPI
- 2310B Loop – rendering provider name
- Identification code qualifier – NM108 = XX
- Identification code – NM109 = rendering provider NPI
- For form CMS-1500, the rendering provider taxonomy code in box 24J. ZZ qualifier in box 24I for rendering provider taxonomy.

The billing provider TIN must be submitted as the secondary provider identifier using an REF segment, which is either the employer identification number for organizations (EIN) or the Social Security number for individuals:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for Social Security number)
- Reference Identification – REF02 = Billing provider TIN or Social Security number
- The billing provider taxonomy code in box 33b

On 5010 (837I) institutional claims, the billing provider NPI should be in the following location:

- 2010AA Loop – Billing provider name
- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = billing provider NPI

The billing provider TIN must be submitted as the secondary provider identifier using an REF segment, which is either the EIN for organizations or the Social Security number for individuals:

- Reference identification qualifier – REF01 = EI (for EIN) or SY (for Social Security number)
- Reference identification – REF02 = Billing provider TIN or Social Security number
- The billing taxonomy code goes in box 81

On all electronic claims, the Humana Healthy Horizons enrollee ID number should go on:

- 2010BA Loop = Subscriber name
- NM109 = Enrollee ID number

## Paper claim submissions

For the most efficient processing of your claims, Humana Healthy Horizons recommends providers submit all claims electronically. To submit paper claims, please use one of the following claim forms:

- CMS-1500, formerly HCFA 1500 form — AMA universal claim form also known as the National Standard Format
- CMS-1450 (UB-04), formerly UB92 form, for facilities

Paper claim submission must be done using the most current form version, as designated by the CMS and the National Uniform Claim Committee (NUCC).

Detailed instructions for completing forms are available at the following websites:

- **CMS-1500 Form Instructions**
- **UB-04 Form Instructions**

Please mail all paper claim forms to Humana Healthy Horizons at the following address:

**Humana Claims Office**
P.O. Box 14601
Lexington, KY 40512-4601

Humana Healthy Horizons uses optical/intelligent character recognition systems to capture claims information to increase efficiency and to improve accuracy and turnaround time. We cannot accept handwritten claims or super bills.

Humana Healthy Horizons also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plan organizations. Local or proprietary codes are no longer allowed.

**Instructions for National Drug Code (NDC) on paper claims**

All of the following information is required for each applicable code required on a claim:

- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable), the 11-digit NDC (this excludes the N4 qualifier), a unit of measurement code (F2, GR, ML or UN are the only acceptable codes), and the metric decimal or unit quantity that follows the unit of measurement code.
- Do not enter a space between the qualifier and the NDC or qualifier and quantity.
- Do not enter hyphens or spaces with the NDC.
- Use three spaces between the NDC and the units on paper forms.

**Tips for submitting paper claims**

- Electronic claims are generally processed more quickly than paper claims.
- If you submit paper claims, we require the most current form version as designated by CMS and NUCC.
- No handwritten claims or super bills, including printed claims with handwritten information, will be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Font size should be 10 to 14 point in black ink. (Capital letters are preferred.)
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- Federal TIN or provider Social Security number is required for all claim submissions.
- All data must be updated and on file with the Kentucky DMS MPL, including TIN, billing and rendering NPI, addresses, and taxonomy codes.
- COB paper claims require a copy of the EOP from the primary carrier.

## Out-of-network claims

Humana Healthy Horizons established guidelines for payments to out-of-network providers for preauthorized medically necessary services. These services will be reimbursed at 65% of the Kentucky Medicaid fee schedule. Please note that preauthorized, medically necessary laboratory services including but not limited to reference/clinical laboratory services, will be reimbursed at 45% of the Kentucky Medicaid fee schedule.

The following HCPCS G-codes are reimbursed at a $40 flat rate: G0480, G0481, G0482, G0483 and G0659.

The following are exceptions to the reimbursement guidelines and are reimbursed at 90% of the Kentucky Medicaid fee schedule:

- Emergency care (nonparticipating professional and facility services provided to enrollees in an emergency room setting)
- Emergency transportation, air ambulance only
  - When submitting air ambulance claims, please attach documentation that substantiates the enrollee's need for air transport. Submitted records should support that air transport prevented loss of life and/or limb or prevented significant morbidity for the enrollee, compared to ground transport. Services billed without medical records are reimbursed at 65% of the Kentucky Medicaid fee schedule.
- Services provided for family planning
- Services for children in foster care

The following exceptions to the reimbursement guidelines are reimbursed at 100% of the Kentucky Medicaid fee schedule and require no prior authorization:

- Pharmacy provider (Provider Type 54) billing for vaccine counseling via medical benefit (CMS 1500/837P) for CPT vaccine code 99401

Humana Healthy Horizons does not adjust previously paid claims in accordance with retroactive fee schedule modifications issued by the Kentucky DMS for existing published codes and modifiers. In those instances when a modification to the Kentucky DMS fee schedule adds a new code or modifier, Humana Healthy Horizons will adjust previously adjudicated claims impacted by such a modification in accordance with all applicable retroactive effective date(s).

## Claim processing guidelines

- Providers have 365 calendar days from the date of service or discharge to submit a claim. If the claim is submitted after the applicable timely filing term, the claim will be denied for timely filing.
- If an enrollee has other insurance and Humana Healthy Horizons is secondary, the provider may submit for secondary payment within six months of the other insurance payment date.
- If a provider does not agree with the decision on a processed claim, they have 60 calendar days from receipt of notification that payment for a submitted claim has been reduced or denied to submit an appeal.
- If a provider indicates that a claim was not paid at the provider's contracted rate, the provider may submit a **Kentucky Contracted Rate Dispute Form**, which must be received by Humana Healthy Horizons within 24 months of the original claim adjudication date. For more information, please refer to the Contracted Rate Dispute Process section of this provider manual.
- If the claim appeal is not submitted in the required time frame, the claim is not considered and the appeal is denied.
- COB electronic claims require a copy of the enrollees' primary carrier's payment information, including the COB indicator of either MA or MB for Medicare coverage and for Medicare Advantage coverage.
- COB claims (including Medicare and commercial) submitted beyond the 365-day limit must have a copy of the appropriate remittance statement that is not more than 180 days from the primary payer's EOB date attached to each claim form involved, to verify that the original claim was received within 365 days of the service date. COB paper claims require a copy of the EOP from the primary carrier. If a copy of the claim and EOB are not submitted within the required time frame, the claim is denied for timely filing.
- If a claim is denied for COB information needed, the provider must submit the primary payer's EOB for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 60 days from the primary payer's EOB date. If a copy of the claim and EOB are not submitted within the required time frame, the claim will be denied for timely filing.
- The Medicaid bypass list for Medicare non-covered codes list and the commercial non-covered codes list are both **available online**.
- All claims for newborns must be submitted using the newborn's Humana Healthy Horizons ID number and Kentucky Medicaid ID number. Newborn infants are deemed eligible for Medicaid and automatically enrolled by the birthing hospital with Humana Healthy Horizons for 60 days. Do not submit newborn claims using the mother's identification numbers, as the claim will be denied. Claims for newborns must include birth weight.
- Abortion, sterilization and hysterectomy procedures and initial hospice claims submissions must have consent forms attached. The CHFS forms are **available online**.
- Claims indicating that an enrollee's diagnosis was caused by the enrollee's employment are not to be paid. The provider will be advised to submit the charges to Workers' Compensation for reimbursement.
- Skilled nursing and hospice claims are processed the same. Both are billed on a UB-04 form. Revenue code 101 for skilled nursing claims for room and board will not be paid. All other revenue codes will process according to guidelines outlined in the Kentucky Medicaid contract.
- Home health providers are required to bill the electronic HIPAA standard institutional claim transaction (837), or the provider can bill a paper form CMS-1450, also known as the UB-04. These claims are processed according to the claims guidelines and processing. Please refer to the Electronic Visit Verification section of this provider manual.
- The Kentucky Physicians Certification Statement Form for Non-Emergent Ground Transportation is required to be completed and submitted along with supporting clinical documentation with the claim submission for nonemergent ground transportation services. The CHFS forms are **available online**.
- Providers are required to report provider-preventable and healthcare-acquired conditions associated with claims for payment or enrollee treatments for which payment would otherwise be made. Claims indicating these conditions are not to be paid. If not submitting a claim, providers are subject to reporting the condition in writing to DMS within 12 months of occurrence.

## Claims compliance standards

Humana Healthy Horizons ensures their compliance target and turnaround times for electronic claims to be paid/ denied comply within the following time frames:

- Humana Healthy Horizons pays 90% of all clean claims submitted within 30 days.
- Humana Healthy Horizons pays 99% of all claims submitted within 90 days.

Humana Healthy Horizons acknowledges all electronically submitted claims for services within the following time frames:

- Within 48 hours of the beginning of the next business day after receipt of the claim, Humana Healthy Horizons will provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.
- Within 30 days of receipt of a clean claim, Humana Healthy Horizons will pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim includes an itemized list of additional information or documents necessary to process the claim.
- Humana Healthy Horizons will pay or deny the claim within 90 days of receipt the claim.

For nonelectronic claims Humana Healthy Horizons ensures its compliance target and turnaround times comply with the following time frames:

- Within 20 days of receipt of the claim, Humana Healthy Horizons will provide acknowledgment of receipt of the claim to the provider or designee or offer the provider or designee with electronic access to the status of a submitted claim.
- Within 30 days of receipt of the claim, Humana Healthy Horizons will pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim includes an itemized list of additional information or documents necessary to process the claim.
- Within 90 days of receipt of the claim, Humana Healthy Horizons will pay or deny the claim.

**Crossover claims**

Humana Healthy Horizons must receive the Medicare EOB with the claim. The claims adjuster reviews to ensure that all fields are completed on the EOB and determines the amount that should be paid out. Crossover claims should not be denied if received within 36 months of the date of service.

## Claim status

You can track the progress of submitted claims at any time through **Availity Essentials**. Claim status is updated daily and provides information on claims submitted in the previous 24 months. Searches by enrollee ID number, enrollee name and date of birth or claim number are available.

Providers can find the following claim information on the provider portal:

- Reason for payment or denial
- Check number(s) and date
- Procedure/diagnostic
- Claim payment date

Claims payments by Humana Healthy Horizons to providers are accompanied by an itemized accounting of the individual claims in the payment including the enrollee's name, the date of service, the procedure code, service units, the reimbursement amount and identification of Humana Healthy Horizons entity.

As required by KRS 205.534(1)(b), Humana Healthy Horizons extends each provider the opportunity for an in-person meeting with a Humana Healthy Horizons representative if a clean claim remains unpaid in violation of KRS 304.17A-700 to 304.17A-730. Additionally, the same opportunity is extended to providers if a claim remains unpaid for more than 45 days after the date the claim was received by Humana Healthy Horizons and claim or claims amount, individually or in the aggregate, exceeds $2,500.

## Code editing

Humana Healthy Horizons uses code editing software to review the accuracy of claim coding, such as the accuracy of diagnosis and procedure codes, to ensure claims are processed consistently, accurately and efficiently.

Our code editing review may identify coding conflicts or inconsistent information on a claim. For example, a claim may contain a conflict between the patient's age and the procedure code, such as the submission for an adult patient of a procedure code limited to services provided to an infant. Humana Healthy Horizons' code editing software resolves these conflicts or indicates a need for additional information from the provider. Humana Healthy Horizons code editing reviews only evaluate the appropriateness of the procedure code, not the medical necessity of the procedure.

Humana Healthy Horizons provides notification of upcoming code editing changes. We **publish new code editing rules** and our rationales for these changes on the first Friday of each month.

## Coding and payment policies

Humana Healthy Horizons strives to be consistent with Kentucky DMS, Medicaid and national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code/code set(s) submitted and related clinical standards for claims received electronically or as a hard copy.

Humana Healthy Horizons applies HIPAA standards to all electronically received claims. Accordingly, only HIPAA-compliant code sets (i.e., HCPCS, CPT and ICD-10) are accepted. In addition, CMS federal rules for Medicare and Medicaid coding standards are followed.

Finally, generally accepted commercial health insurance rules regarding coding and reimbursement also are used when appropriate. Humana Healthy Horizons strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

To determine unit prices for a specific code or service, please refer to the **online fee schedules**.

Humana Healthy Horizons uses coding industry standards, such as the American Medical Association (AMA) CPT manual, NCCI and input from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including:

- Bundling issues
- Diagnosis to procedure matching
- Gender and age appropriateness
- Maximum units of a code per day
- Valid CPT/HCPCS code or modifier usage

Humana Healthy Horizons seeks to apply fair and reasonable coding edits. Humana Healthy Horizons maintains a provider appeals function that reviews, on request, a claim denied based on the use of a certain code, the relationship between two or more codes, unit counts or the use of modifiers. This review takes into consideration the previously mentioned Kentucky DMS, Medicaid, NCCI and national commercial standards when considering an appeal.

To ensure all relevant information is considered, appropriate clinical information should be supplied with the claim appeal. This clinical information allows the Humana Healthy Horizons appeals team to consider why the code set(s) and modifier(s) being submitted differ from the standards inherent in our edit logic. The clinical information may provide evidence that overrides the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Specific claims are subject to current Humana Healthy Horizons claim logic and other established coding benchmarks. Consideration of a provider's claim payment concern regarding clinical edit logic is based on review of generally accepted coding standards and the clinical information particular to the specific claim in question.

## Fee schedules

From time to time, Kentucky DMS updates fee schedules for existing published codes and modifiers allowable for Kentucky Medicaid recipients. Humana Healthy Horizons does not adjust previously paid claims in accordance with retroactive fee schedule modifications issued by Kentucky DMS.

We publish the date we update our **claims adjudication system to the new rate online** providing the effective date of the systems configuration.

In the event a modification to the Kentucky DMS fee schedule includes the addition of a new code or modifier, Humana Healthy Horizons adjusts previously adjudicated claims impacted by such a modification in accordance with all applicable retroactive effective dates.

Reimbursement of published fee schedules are subject to provisions with in-network provider contract agreements and the **Out of Network Claims Payment Policy**.

The following provider types are included in this policy:

- Advanced registered nurse practitioner (ARNP) - 78, 789
- Ambulatory surgical centers - 36
- Audiologist - 70, 709
- Behavioral health multi-specialty group - 66
- Behavioral health services organization - 03

- Birthing centers - 73
- Certified registered nurse anesthetist (CRNA) - 74, 749
- Chiropractor - 85, 859
- Community mental health centers - 30
- Comprehensive outpatient rehabilitation facilities - 91
- Dentist - 60, 61
- EPSDT services - screenings - 45
- EPSDT services - special services - 45
- Emergency transportation - 55
- Family planning services - 32
- FQHC/Non-FQHC - 31
- Hearing aid dealer - 50, 509
- Home health services - 34
- Hospice services - 44
- Hospitals - 01
- Independent laboratory and radiological services - 37
- Licensed behavioral analyst - 63, 639
- Licensed clinical alcohol and drug counselor - 67, 679
- Licensed clinical social worker - 82, 829
- Licensed marriage and family therapist - 83, 839
- Licensed professional art therapist - 62, 629
- Licensed professional clinical counselor - 81, 819
- Licensed psychological practitioner - 84, 849
- Licensed psychologist - 89, 899
- Multi-therapy agency - 76
- Nonemergency transportation - 56
- Nursing facility - 12
- Occupational therapist - 88, 889
- Optician - 52, 529
- Optometrist - 77, 779
- Physical therapist - 87, 879
- Physician assistant - 95, 859
- Physician services - 64, 65
- Podiatry services - 80, 809
- Primary care - 31
- Private duty nursing (PDN) - 18
- Psychiatric distinct part unit (DPU) - 92
- Psychiatric hospital - 02
- Psychiatric residential treatment facility I - 04
- Psychiatric residential treatment facility II - 05
- Radiological services and other lab and X-ray - 86
- Rehabilitative distinct part unit (DPU) - 93
- Renal dialysis service - 39
- Residential crisis stabilization unit - 26
- Rural health services - 35
- Specialized children’s services clinic or child advocacy centers - 13
- Speech-language pathologist - 79, 799
- Targeted case management and rehab services provided through title V services – 23

## Electronic visit verification (EVV)

Electronic visit verification (EVV) is an electronic system providers use to record information when delivering certain in-home or community-based 1915(c) home- and community-based services (HCBS) or home healthcare services (HHCS). The Kentucky DMS has transitioned to EVV for its 1915(c) HCBS waivers. Jan. 1, 2024, DMS transitioned HHCS to EVV. The use of EVV is a requirement of the Cures Act passed by congress in 2016.

EVV must electronically verify six aspects of service delivery: the date, location and type of service, the individual providing the service, the individual receiving the service, and the start and end times of the service.

EVV offers several benefits such as eliminating the need for paper documentation, creating flexibility in scheduling and delivering services, improved monitoring of participant health, safety and welfare, and reduction in potential Medicaid fraud, waste and abuse.

More information regarding EVV is available through the **CHFS**.

## Prepayment reviews for fraud, waste or abuse purposes

The provider has 45 calendar days to submit documents in support of claims under prepayment review. Humana Healthy Horizons denies claims for which the requested documentation was not received by day 46. Humana Healthy Horizons denies claims when the submitted documentation lacks evidence to support the service or code. Humana Healthy Horizons follows KRS 205.646 for any appeals related to the prepayment process. A provider has 60 days to submit an appeal. Humana Healthy Horizons may extend the length of a prepayment review when it is determined necessary to prevent improper payments. If the provider sustained a 90% error-free claims submission rate to Humana Healthy Horizons for 45 calendar days, Humana Healthy Horizons must request express permission to continue prepayment review from the director of program integrity (or designee) and the director of program quality and outcomes (or designee).

## Suspension of provider payments

A network provider's claim payments are subject to suspension when the Kentucky DMS Division of Program Integrity determines there is a credible allegation of fraud in accordance with 42 C.F.R. 455.23. Humana Healthy Horizons, at the direction of Kentucky DMS, adjudicates claims to an escrow account until Kentucky DMS authorizes Humana Healthy Horizons to release the payment. A remittance advice is issued to the provider that states, "Payment has been placed in escrow, per state regulations."

## Coordination of Benefits (COB)

Humana Healthy Horizons collects COB information for our enrollees. This information helps Humana Healthy Horizons ensure claims are paid appropriately and comply with federal regulations that Medicaid programs are the payer of last resort.

While Humana Healthy Horizons tries to maintain accurate information at all times, Humana Healthy Horizons relies on numerous sources for information updated periodically, and some updates may not always be fully reflected on our provider portal. Please ask Humana Healthy Horizons enrollees for all healthcare insurance information at the time of service.

You can search for COB information on **Availity Essentials** by:

- Enrollee number
- Case number
- Medicaid number/MMIS number
- Enrollee name and date of birth

You can check COB information for enrollees active with Humana Healthy Horizons within the last 12 months.

Claims involving COB will not be paid until an EOB/EOP or EDI payment information file is received, indicating the amount the primary carrier paid. Claims indicating the primary carrier paid in full (i.e., $0 balance) still must be submitted to Humana Healthy Horizons for processing due to regulatory requirements. Please see the Medicaid Bypass List for Medicare Non-covered Codes section of this provider manual for bypass code information.

**COB overpayment**

When a provider receives a payment from another carrier after receiving payment from Humana Healthy Horizons for the same items or services, Humana Healthy Horizons considers this an overpayment. Humana Healthy Horizons provides 30-days' written notice to the provider before an adjustment for overpayment is made. If a dispute is not received from the provider, adjustments to the overpayment are made on a subsequent reimbursement. Providers also can issue refund checks to Humana Healthy Horizons for overpayments and mail them to the following address:

**Humana Healthcare Plans**
P.O. Box 931655
Atlanta, GA 31193-1655

Providers should not refund money paid to an enrollee by a third party.

## Enrollee billing

Providers should collect copayments from enrollees when applicable, as copayment amounts are subtracted from claim payments for services. See the copayment section of this provider manual for more information.

State requirements and federal regulations prohibit providers from billing Humana Healthy Horizons enrollees for medically necessary covered services except under very limited circumstances. Providers who knowingly and willfully bill an enrollee for a Medicaid-covered service are guilty of a felony and on conviction are fined, imprisoned or both, as defined in the Social Security Act.

Humana Healthy Horizons monitors this billing policy activity based on complaints of billing from enrollees. Failure to comply with regulations after intervention may result in both criminal charges and termination of a provider's agreement with Humana Healthy Horizons.

Government regulations stipulate providers must hold enrollees harmless in the event Humana Healthy Horizons does not pay for a covered service performed by the provider. Enrollees cannot be billed for services that are administratively denied. The only exception is if a Humana Healthy Horizons enrollee agrees in advance, in writing, to pay for a non-Medicaid covered service. This agreement must be completed prior to providing the service and the enrollee must sign and date the agreement acknowledging their financial responsibility. The form or type of agreement must specifically state the services or procedures that are not covered by Medicaid.

Providers should call Provider Services at **800-444-9137** for guidance before billing enrollees for services.

## Missed appointments

In compliance with federal and state requirements, Humana Healthy Horizons enrollees cannot be billed for missed appointments. Humana Healthy Horizons encourages enrollees to keep scheduled appointments and to call to cancel ahead of time, if needed.

## Enrollee termination claim processing

**From Humana Healthy Horizons to another plan**

In the event of an enrollee's termination of enrollment with Humana Healthy Horizons into a different Medicaid plan, Humana Healthy Horizons may submit voided encounters to Kentucky DMS and notify providers of adjusted claims using the following process:

1. On daily receipt of the 834 eligibility file from Kentucky DMS, Humana Healthy Horizons identifies which enrollees received a retroactive eligibility date and require termination of enrollment within the Humana Healthy Horizons claims payment system.
2. Humana Healthy Horizons initiates the enrollee termination process. This is completed within five business days of receipt of the 834 file.
3. Humana Healthy Horizons determines whether claims were paid for dates of service in which the enrollee was afterward identified as ineligible for Medicaid benefits with Humana Healthy Horizons. This process is completed within five business days.
4. Humana Healthy Horizons sends a notice to each affected provider that recoupment of payment will occur for the claim(s) identified in the recoupment letter. The provider is given 30 calendar days to respond to the notice.

5. Once the 30 days expires, if the affected provider has not attempted to appeal the recoupment of payment or has not submitted a refund check before 30 calendar days expires, Humana Healthy Horizons adjusts the payment(s) for the affected claims listed in the notice letter. This takes place within 10 business days.
6. The provider receives an EOP reflecting the funds recouped. This takes place within five business days of completion of payment adjustment(s).
7. After the recoupment receives a processed date stamp, a voided encounter for the affected claims is submitted to Kentucky DMS within 10 business days, assuming the original submitted encounter was previously accepted. Please note if the original encounter was denied or rejected by Kentucky DMS, a void does not need to occur.
8. On successful completion of the encounter-void process, affected providers are sent a courtesy letter informing them the original payment was successfully cleared from the Kentucky DMS system and they can proceed in billing the claim(s) with the enrollee's current active Medicaid plan. The courtesy letter is sent within five business days. Please note that if the Kentucky DMS did not accept the voided encounter, the process may be delayed an additional 10 business days.

If the provider experiences continued issues receiving payment from another Medicaid plan within 60 days of the issued EOP reflecting recoupment of payments and the issued courtesy letter, Humana Healthy Horizons encourages providers to contact the enrollee's current Medicaid managed care plan for the claim(s) dates of service.

**From another plan to Humana Healthy Horizons**

If an enrollee was previously enrolled with another Medicaid plan and is now eligible with Humana Healthy Horizons, providers are required to submit a copy of the EOP reflecting recoupment of payment and documentation from the previous MCO to validate the original encounter was voided and accepted by Kentucky DMS. These items are used to support overriding timely filing, if eligible. If a claim has exceeded timely filing due to retroactive eligibility from another Medicaid plan, the provider has 90 days from the date of the accepted voided encounter to submit the claim to Humana Healthy Horizons to avoid timely filing denials.

**Humana Healthy Horizons**
Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax the form or letter to **800-949-2961**.

Humana Healthy Horizons sends an acknowledgement letter within five business days of the receipt of the appeal. If the appeal request was received by telephone, the acknowledgement letter will include a written appeal request form that must be signed and returned to us. We consider this your written request. Humana Healthy Horizons must receive it within 10 calendar days of your telephone call.

If we extend the time frame for the appeal or expedited appeal, we make reasonable efforts to provide a prompt oral notice of the delay. Humana Healthy Horizons also sends written notice within two calendar days of the reason for the decision to extend the time frame. We also inform the enrollee of the right to file a grievance if there is disagreement with that decision. After we complete the review of the appeal, we send a letter within 30 calendar days advising of our decision. The enrollee or someone chosen by the enrollee can:

- Review all of the information used to make the decision
- Provide more information throughout the appeal review process
- Examine the enrollee's case file before and during the appeals process
  - This includes medical, clinical records, other documents and records, and all new or additional evidence considered, relied upon, or generated in connection with the appeal.
  - This information shall be provided, on request, free of charge and sufficiently in advance of the resolution time frame.

If the enrollee or appointed representative feels waiting for the 30-day time frame to resolve an appeal could seriously harm the enrollee's health, they can request that we expedite the appeal. For the appeal to be expedited, it must meet the following criteria:

- Failure to expedite could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

We make decisions on expedited appeals within 72 hours or as quickly as needed based on the enrollee's health. Negative actions will not be taken against:

- An enrollee or provider who files an appeal
- A provider who supports an enrollee's appeal or files an appeal or expedited appeal on behalf of an enrollee with written consent

**State fair hearings**

Enrollees or their appointed representatives also have the right to ask for a state fair hearing from Kentucky DMS after Humana Healthy Horizons completes its appeal process. Requests must be made within 120 days of the date on the Humana Healthy Horizons appeal decision letter.

To request a state fair hearing:

- Call: **800-635-2570**
- Write:
  **Kentucky Department for Medicaid Services**
  Division of Program Quality and Outcomes
  275 E. Main St. 6C-C
  Frankfort, KY 40621
- Fax: **502-564-0223**

Enrollees that request a state fair hearing and want their Humana Healthy Horizons benefits to continue must file a request with Humana Healthy Horizons within 10 days of the date on the notice of plan appeal resolution.

Enrollees with an urgent health condition can ask for an expedited hearing. If the hearing finds that Humana Healthy Horizons' decision was correct, the enrollee may have to pay the cost of the services provided for the benefits that were continued during the Medicaid state fair hearing.

**Continuation of benefits**

For some adverse benefit determinations, enrollees can request to continue services during the appeal and Medicaid state fair hearing process. Continued services must be services the enrollee already receives, including those services that are being reduced or terminated.

Humana Healthy Horizons continues services if you request an appeal within 10 days of the date on the notice of adverse benefit determination letter, or before the date we advised they would be reduced or terminated, whichever is later. Enrollee benefits continue until one of the following occurs:

- The original authorization period for services ends.
- 10 days elapse since we mail the appeal decision.
- The enrollee withdraws the appeal.
- Following a Medicaid state fair hearing, the administrative law judge issues a decision that is not in the enrollee's favor.

If the appeal was denied and a request for a Medicaid state fair hearing with continuation of services is received within 10 days of the date on the appeal resolution letter, the services will continue during the Medicaid state fair hearing. Please see the Enrollee Grievances, Appeals and State Fair Hearing Requests section of this provider manual.

However, if we decide we agree with our first decision to deny your service, the enrollee may be required to pay for these services.

## Grievance and appeals

**Provider grievance and appeals**

The provider has the right to file a grievance or appeal with Humana Healthy Horizons regarding a healthcare service, claim for reimbursement, provider payment or a contractual issue.

A grievance is a complaint. An appeal is a request to change a previous decision made by Humana Healthy Horizons. For purposes of this section, coverage denial is Humana Healthy Horizons' determination that a treatment or service is specifically limited or excluded under the enrollee's specified health benefit plan. When a coverage denial is involved, the provider may request an internal appeal.

As a provider, you can file grievances and appeals on your own behalf. You can file an appeal on behalf of an enrollee if you have the enrollee's written consent. To file on behalf of an enrollee, please visit the Enrollee Grievances Appeals, and State Fair Hearing Request section in this provider manual. Humana Healthy Horizons ensures that no punitive or retaliatory action is taken against an enrollee or provider who files a grievance or appeal or a provider who supports an enrollee's grievance or appeal.

**Internal appeals**

If a provider does not agree with the decision on a processed claim, the provider has 60 calendar days from the date of the original claim submission adjudication to file an appeal. If the claim appeal is not submitted in the required time frame, the claim is not considered and the appeal is denied. If the appeal is denied, the provider is notified in writing. If the appeal is approved, payment shows on the EOP. Humana Healthy Horizons resolves provider grievances and appeals within 30 calendar days of receipt of the appeal request. Humana Healthy Horizons may request a 14-day extension to resolve a grievance or appeal.

Internal appeal determination letters include:

- A statement of the specific medical and procedural reasons for denying coverage or identifying the provision of the schedule of benefits or exclusions that demonstrates coverage is not available
- The state of licensure and the title of the person making the decision
- Except for retrospective review, a description of alternative benefits, services or supplies covered by the health benefit plan, if any
- Instructions for initiating an external review of an adverse determination or filing a request with Kentucky DMS if a coverage denial is upheld by Humana Healthy Horizons on internal appeal

Please note: If you believe a claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. You do not need to file an appeal. Providers have 365 calendar days from the date of service or discharge to submit a corrected claim.

**Written submission**

Providers can submit appeals in writing to:

**Humana Provider Correspondence**
Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax: **800-949-2961**

**Verbal submission**

If you have an inquiry, dispute, appeal or complaint, please call Provider Services at **800-444-9137**. Based on the type of issue, a Humana Healthy Horizons associate with the designated authority will review your issue or complaint. To file a written appeal, mail your appeal request to the following address:

**Humana Healthy Horizons**
Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax: **800-949-2961**

**Digital submission**

Providers can submit encrypted grievances regarding claim issues or appeals online via **Availity Essentials**. Additionally, providers can submit supporting documentation and check the status of grievances and appeals via Availity Essentials.

**Expedited process**

You may request an expedited appeal of either an adverse determination or a coverage denial and receive a decision no later than 72 hours after receipt of the request. A provider may file an expedited appeal only on behalf of the enrollee. Please see the Enrollee Grievances, Appeals and State Fair Hearing section in this provider manual for more information. An expedited appeal is deemed necessary when a covered person is hospitalized or if you believe the standard appeal time frame would result in:

- Placing the health of the enrollee (or pregnant woman and the unborn child) in serious jeopardy

- Serious impairment to bodily functions
- Serious dysfunction of a body organ or part

**External independent reviews**
Humana Healthy Horizons complies with all rights and requirements conferred to providers, pursuant to 907 KAR 17:035. After a provider exhausts all internal appeal rights, the provider can request an external independent review. A provider cannot request an external independent review if the enrollee has exercised their right for a state fair hearing. The provider must submit a request for an external independent review within 60 calendar days of receiving final decision on the internal appeal.

After Humana Healthy Horizons receives a request from a provider for an external independent review, Humana Healthy Horizons sends the provider an acknowledgement letter within five business days. The external independent review entity issues a final decision with 30 calendar days of receiving the review packet from Humana Healthy Horizons. Humana Healthy Horizons and the provider both have the right to appeal the decision of the external independent review entity to an administrative hearing. The request for an administrative hearing must be received by the state within 30 calendar days of the external independent review entity's decision.

**Kentucky DMS request for review of coverage denials**
If you have exhausted Humana Healthy Horizons' internal appeals process, including review by an external third party, you may appeal the third party's final decision to the Kentucky CHFS Division of Administrative Hearings. After the issuance of a final decision by an external independent third-party reviewer, Kentucky DMS will notify you and Humana Healthy Horizons in writing of the right of the party that received an adverse final decision to appeal the decision by requesting an administrative hearing.

A written request for an administrative hearing must be sent to the Kentucky CHFS Division of Administrative Hearings within 30 calendar days of the date on the written notice. The hearing officer's decision will be issued within 60 calendar days of the close of the official record of the administrative hearing. The party that receives an adverse final order shall pay a fee of $600 to Kentucky DMS within 30 calendar days of the issuance of the final order.

The request must contain the following:
- Clear identification of each specific issue and dispute directly related to the adverse final decision issued by the external independent third-party reviewer
- Clear statements of the bases on which the external independent third-party reviewer's decision on each issue is believed to be erroneous
- The name, mailing address and telephone number of individuals who may be contacted about the request for administrative hearing
- The mailing address, fax number, email address or other contact information to which the MCO confirmation of receipt of request shall be sent

Request should be sent to:
**Cabinet for Health and Family Services**
**Department for Medicaid Services**
**Division of Program Quality and Outcomes**
275 East Main Street 6C-C
Frankfort, KY 40621
Fax: **502-564-0223**
Email: DMS.Hearings@ky.gov

## Enrollee grievances, appeals and state fair hearing requests

**Grievances (complaints)**
Enrollees may file a grievance when they are dissatisfied with Humana Healthy Horizons or a provider. Providers may assist enrollees in filing a grievance when the enrollee provides written consent. Grievances can be filed verbally or in writing by:
- Calling Enrollee Services at **800-444-9137 (TTY: 711)**
- Filling out the form in the back of the enrollee handbook

- Writing a letter that includes the following information:
  - Enrollee name
  - Enrollee ID number from the front of the Humana Healthy Horizons ID card
  - Enrollee address and phone number
  - Explanation of issue

To submit written grievances, mail the form or letter to:
**Humana Healthy Horizons**
Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax the form or letter to: **800-949-2961**

Humana Healthy Horizons sends an acknowledgement letter within five business days of the day the grievance is received.

Following Humana Healthy Horizons' review, a letter is sent within 30 calendar days advising of the decision. Negative actions are not taken against:
- An enrollee who files a grievance
- A provider who supports an enrollee's grievance or files a grievance on behalf of an enrollee with written consent

**Appeals**
If the enrollee isn't satisfied with a decision or action Humana Healthy Horizons takes, an appeal can be filed by the enrollee or their authorized representative. Appeals must be filed within 60 calendar days of the date on the notice of adverse benefit determination.

Appeals can be filed by:
- Calling Enrollee Services at **800-444-9137 (TTY: 711)**
- Filling out the form in the back of the enrollee handbook
- Writing a letter that includes the following information:
  - Enrollee name
  - Enrollee ID number from the front of the Humana Healthy Horizons ID card
  - Enrollee address and phone number
  - All information that will help explain the appeal

Mail the form or letter to:
**Humana Healthy Horizons**
Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax the form or letter to: **800-949-2961**

## Provider roles and responsibilities

**Provider responsibilities**
Participating providers are expected to treat enrollees with respect. Humana Healthy Horizons enrollees should not be treated differently than patients with other healthcare insurance. Please reference the Enrollee Rights and Responsibilities section of this provider manual.

Participating providers are expected to make daily visits to their patients who are admitted as inpatients to an acute care facility or arrange for a colleague to visit. Participating PCPs are expected to have a system in place for following up with patients who miss scheduled appointments.

Humana Healthy Horizons expects participating providers to verify enrollee eligibility and ask for their healthcare insurance information before rendering services, except in an emergency. You can verify enrollee eligibility on **KYHealthNet** and obtain information for other healthcare insurance coverage by accessing **Availity Essentials**.

For all Medicaid services provided by Humana Healthy Horizons that require the completion of a specific form (e.g., hospice, sterilization, early elective delivery, hysterectomy or abortion), the form needs to be completed according to the appropriate Kentucky Administrative Regulation and submitted with the procedure claim or initial hospice claim. Claims are not paid until the provider submits the completed form. Humana Healthy Horizons allows either medical records or completion of a designated form as documentation when submitting early elective delivery claims. The completed forms should be included in the enrollee's chart in the event of audit and, on request, a copy should be submitted to Kentucky DMS. The **CHFS forms are available online**.

**Provider status changes**

Advance written notice of status changes, such as a change in address or phone number, or addition or removal of a provider at your practice, should be sent to **ProviderDevelopmentKYWV@humana.com**, or for behavioral health providers, **KYBHMedicaid@humana.com**. This helps us keep our records current and is critical to process your claims. In addition, it ensures our provider directories are up to date and reduces unnecessary calls to your practice. This information also is reportable to CMS.

**Timelines for provider changes:**

| Type of change | Minimum notice required |
|---|---|
| **New healthcare providers or providers leaving the practice, ownership changes, or convictions** | Immediate |
| **Phone number change** | 10 calendar days |
| **Address change** | 60 calendar days |
| **Change in capacity to accept enrollees** | 60 calendar days |
| **Healthcare provider's intent to terminate** | 90 days or as specified in provider agreement |

## PCPs

All Humana Healthy Horizons enrollees choose or are assigned to a PCP on enrollment in the plan. PCPs help facilitate a "medical home" for enrollees. This means PCPs help coordinate healthcare for the enrollee and provide additional health options to the enrollee for self-care or care from community partners. PCPs also are required to know how to screen and refer enrollees for behavioral health conditions. Please refer to the Behavioral Health and Substance Use Services section of this provider manual for more information.

Enrollees select a PCP from our provider directory. Enrollees have the option to change to another participating PCP as often as needed. Enrollees initiate the change by calling Enrollee Services at **800-444-9137**. PCP changes are effective on the first day of the month following the requested change.

When enrollees change PCPs, the medical records or copies of medical records should be forwarded to the new PCP within 10 days of receipt of request. The PCP is required to have enrollees sign a release of medical records before a medical record transfer occurs.

**Education**

Humana Healthy Horizons conducts an initial educational orientation for all newly contracted providers within 30 days of activation. Providers receive periodic and/or targeted education as needed.

**Roles and responsibilities**

PCPs:

- Supervise, coordinate and provide initial and primary care to enrollees
- Initiate referrals for specialty care as needed
- Maintain the continuity of patient care

In addition, Humana Healthy Horizons PCPs play an integral part in coordinating healthcare for our enrollees by providing:

- Availability of a personal healthcare provider to assist with coordinating an enrollee's overall care, as appropriate for the enrollee
- Continuity of the enrollee's total healthcare

- Early detection and preventive healthcare services
- Elimination of inappropriate and duplicate services
- PCP care-coordination responsibilities, which include, at a minimum:
  - Treating Humana Healthy Horizons enrollees with the same dignity and respect afforded to all patients—including standards of care and hours of operation
  - Maintaining continuity of the enrollee's healthcare
  - Identifying the enrollee's health needs and taking appropriate action
  - Providing phone coverage for handling patient calls 24 hours a day, seven days a week
    - Refer to the PCP After-hours Availability section for more details.
- Referrals for specialty care and other medically necessary services, both in- and out-of-network (when such services are not available within the Humana Healthy Horizons network)

The following are PCP responsibilities:

- Following all referral and PA policies and procedures as outlined in this manual
- Complying with the quality standards of Humana Healthy Horizons and the commonwealth of Kentucky as outlined in this manual
- Discussing advance medical directives with all enrollees as appropriate
- Providing 30 days of emergency coverage to a patient dismissed from the practice
- Maintaining clinical records, including information about pharmaceuticals, referrals, inpatient history, and documentation of all PCP and specialty care services, etc., in a complete and accurate medical record that meets or exceeds Kentucky DMS specifications
- Obtaining patient records from facilities visited by Humana Healthy Horizons-covered patients for emergency or urgent care if notified of the visit
- Ensuring demographic and practice information is up to date for directory and enrollee use (providers are strongly encouraged to provide their race and ethnicity for Humana Healthy Horizons to reference when a member calls requesting a provider with the same race, ethnicity and language as themselves)
- Referring enrollees to behavioral health providers and arranging appointments, when clinically appropriate
- Serving as the ongoing source of primary and preventive care, including ESPDT for enrollees younger than 21
- Recommending referrals to specialists
- Participating in the development of care management and treatment plans, and notifying Humana Healthy Horizons of enrollees who may benefit from care management
- Maintaining formalized relationships with other PCPs to refer their enrollees for after-hours care during certain days and for certain services or other reasons to extend their practice

Providers understand and agree that provider performance data can be used by Humana Healthy Horizons.

## Advance medical directives

PCPs have the responsibility to discuss advance medical directives with enrollees 18 or older who are of sound mind at the first medical appointment. The discussion should be charted in the enrollee's permanent medical record. A copy of the advance directive should be included in the enrollee's medical record inclusive of other mental health directives.

The PCP should discuss potential medical emergencies with the enrollee and document that discussion in the enrollee's medical record.

## Key contract provisions

We outlined key components of your contract with Humana Healthy Horizons in this manual. These key components strengthen our relationship with you and enable us to keep our commitment to improve the healthcare and well-being of our enrollees. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of our enrollees. Unless otherwise specified in a provider's contract, the following standard key contract terms apply.

Participating providers are responsible for:

- Providing Humana Healthy Horizons with advance written notice of intent to terminate an agreement with us
  - This must be done in a manner consistent with the terms in your participation agreement and submitted on your organization's letterhead.

- Sending the required 60-day notice if you plan to close your practice to new patients
  - If we are not notified within this time period, you will be required to continue accepting Humana Healthy Horizons enrollees for a 60-day period following notification.
- Submitting claims and corrected claims within 365 calendar days of the date of service or discharge
- Filing appeals within 60 calendar days of receipt of notification that payment for a submitted claim was reduced or denied
- Keeping all demographic and practice information up to date

Our agreement also indicates that Humana Healthy Horizons is responsible for:

- Paying 90 percent of clean claims within 30 days of receipt
- Providing you with an appeals procedure for timely resolution of requests to reverse a Humana Healthy Horizons determination regarding claim payment
  - Our appeal process is outlined in the Grievances and Appeals section of this provider manual.
- Offering a 24-hour nurse triage phone service for enrollees to reach a medical professional at any time with questions or concerns
- Coordinating benefits for enrollees with primary insurance up to our allowable rate for covered services
  - If the enrollee's primary insurance pays a provider equal to or more than the Humana Healthy Horizons fee schedule for a covered service, Humana Healthy Horizons does not pay any additional amount.
  - If the enrollee's primary insurance pays less than the Humana Healthy Horizons fee schedule for a covered service, Humana Healthy Horizons reimburses the difference up to the Humana Healthy Horizons allowable rate.

These are just a few of the specific terms of our agreement. In addition, we expect participating providers to follow industry standard-practice procedures even though they may not be spelled out in our provider agreement.

## Kentucky Prescription Assistance Program (KPAP)

Humana Healthy Horizons is required to ensure behavioral health service providers assist enrollees in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs. More information, including a listing of KPAP community organizers and coverage areas is **available online**.

## PCP Quality Recognition Programs

Humana Healthy Horizons is committed to reducing cost and improving care in the communities we serve. We developed value-based programs that allow PCPs to earn financial incentives based on quality and clinical outcomes. The programs are designed based on the provider's panel size and engagement. The program is reviewed and reimbursed annually.

Annual payments are made one quarter in arrears to allow for reporting/data collection.

## Kentucky Health Information Exchange

Humana Healthy Horizons encourages providers to connect and sign the participation agreement with the Kentucky Health Information Exchange (KHIE).

Hospitals also must submit ADT messages to KHIE. If providers do not have an EHR, Humana Healthy Horizons contracted providers must still sign a participation agreement with KHIE and sign up for direct secure messaging services to share clinical information securely with other providers in their community of care. Humana Healthy Horizons submits a monthly report regarding provider compliance to the Kentucky Office of Health Data and Analytics. Please note that Kentucky DMS may, at its discretion, mandate provider participation with at least 90 days written notice to Humana Healthy Horizons.

The KHIE is an interoperable network in which participating providers with certified electronic health record technology (CEHRT) can access, locate and share needed patient health information with other providers at the point of care.

The KHIE provides a common, secure electronic information infrastructure that meets national standards to ensure interoperability across various health systems, while affording providers the functionality to support preventive health and disease management. KHIE serves as the intermediary for public health reporting in the commonwealth of Kentucky and works with providers and hospitals. Ultimately, KHIE strives to improve care coordination and overall health outcomes while facilitating the adoption, integration and the meaningful use of CEHRT.

Visit the KHIE website and learn how to make the **KHIE connection**.

## Americans with Disabilities Act (ADA)

All Humana Healthy Horizons-contracted healthcare providers must comply with the Americans with Disabilities Act (ADA), as well as all applicable state and/or federal laws, rules and regulations. More details are available in the Humana Healthy Horizons provider agreement under Compliance with Regulatory Requirements.

Humana Healthy Horizons develops individualized care plans that take into account enrollees' special and unique needs. Healthcare providers with patients who require interpretive services may call **877-320-2233** or email accessibility@humana.com with date, time, provider phone number and location for an appointment. Please do not include patient health information when emailing.

If you have enrollees who need interpretation services, they can call the number on the back of their enrollee ID cards or visit the accessibility resources page of the Humana Healthy Horizons website.

## Cultural competency

Participating providers are expected to provide services in a culturally competent manner, which includes removing all language barriers to service and accommodating the special needs of the ethnic, cultural and social circumstances of the patient.

Participating providers also must meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, ADA and the Rehabilitation Act of 1973.

Humana Healthy Horizons recognizes cultural differences and the influence race, ethnicity, language and socioeconomic status have on the healthcare experience and health outcomes. Humana Healthy Horizons is committed to developing strategies that eliminate health disparities and address gaps in care.

A report by the Institute of Medicine in 2002 confirmed the existence of racial and ethnic disparities in healthcare. Racial differences were found in the type of care delivered across a wide range of healthcare settings and disease conditions, even when controlling for socioeconomic status. Annual national healthcare disparities reports from the Agency for Healthcare Research and Quality (AHRQ) confirm these gaps persist in the American healthcare system.

Communication is paramount in delivering effective care. Mutual understanding may be difficult during cross-cultural interaction between patients and providers. Some disparities may be attributed to miscommunication between providers and patients, language barriers, cultural norms and beliefs, and attitudes that determine healthcare-seeking behaviors. Providers can address racial and ethnic gaps in healthcare with an awareness of cultural needs and improve communication with a growing number of diverse patients.

Humana Healthy Horizons offers a number of initiatives to deliver services to all enrollees regardless of ethnicity, socioeconomic status, culture or primary language. These include language assistance services, race and ethnicity data collection and analysis, internal staff training, and Spanish resources. Other initiatives give providers resources and materials, including tools from health-related organizations, which support awareness of gaps in care and information on culturally competent care.

A copy of the Humana Healthy Horizons cultural competency plan is provided at no charge to the provider. Humana Healthy Horizons' cultural competency plan is available online. To request a paper copy, please call Humana Healthy Horizons Provider Services at **800-444-9137**.

## Marketing materials

No marketing materials are distributed through the Humana Healthy Horizons provider network. If Humana Healthy Horizons supplies branded health education materials to its provider network, distribution is limited to Humana Healthy Horizons enrollees and not available to those visiting the provider's facility. Such branded health education materials do not provide enrollment or disenrollment information.

## Provider training

Humana Healthy Horizons requires adherence to all compliance-based training programs. This includes agreement and assurance that all affiliated participating providers, along with supporting healthcare providers and staff with member interaction receive training on the identified compliance material. Member interaction can involve any of the following: face-to-face and/or over-the-phone conversation, as well as review and/or handling of correspondence via mail, email or fax.

Annual compliance training must be completed on the following topics, as required by Section 6032 of the Federal Deficit Reduction Act of 2005, Humana Healthy Horizons' contract with the Kentucky Department of Health and/or our compliance program:

- General compliance
- Combating fraud, waste and abuse
- Medicaid provider orientation training
- Cultural competency
- Health, safety and welfare (abuse, neglect and exploitation) of enrollees

Your organization is responsible for developing or adopting another organization's training on the separate topics of general compliance and combatting fraud, waste and abuse. While Humana Healthy Horizons does not require an organization-level attestation regarding training on these topics, Humana Healthy Horizons reserves the right, at any time, to request evidence that such training occurs and is sufficient.

**Note:** An attestation at the organization level must be submitted annually to certify that your organization has a plan in place to comply with and conduct training on Medicaid-required topics.

The training on the topics outlined above is designed to ensure the following:

- Sufficient knowledge of how to effectively perform the contracted function(s) to support enrollees
- The presence of specific controls to prevent, detect and/or correct potential, suspected or identified noncompliance and/or fraud, waste or abuse

Online training modules for the topics listed above, as well as an organization-level attestation form, can be accessed online at **Humana.com/ProviderCompliance**.

Information about **additional provider training** is available online.

## Enrollee rights and responsibilities

As a Humana Healthy Horizons-contracted provider, you are required to respect the rights of our enrollees. Humana Healthy Horizons enrollees are informed of their rights and responsibilities via their enrollee handbook. The list of our enrollee's rights and responsibilities is below.

All enrollees are encouraged to take an active and participatory role in their own health and the health of their family. Enrollees have the right:

- To prepare advance medical directives, pursuant to KRS 311.621 and 311.643
- To receive all services the plan must provide and to get them in a timely manner
- To get timely access to care without communication or physical access barriers
- To have reasonable opportunity to choose the provider that gives them care whenever possible and appropriate
- To choose a PCP and change to another PCP in Humana Healthy Horizons' network

- We send enrollee notification in writing that says who the new PCP is when a change is made.

- To request a provider who has the same race, ethnicity and/or language as the enrollee if there is a provider available in their network
- To receive a second opinion from a qualified provider in or out of our network

- If a qualified network provider is not able to see the enrollee, we must set up a visit with a non-network provider.

- To get timely access and referrals to medically-indicated specialty care
- To be protected from liability for payment
- To receive information about their health

- This information also may be given to someone the enrollee has legally approved to have the information, or it may be given to someone the enrollee said should be reached in an emergency when it is not in the best interest of the enrollee's health to give it to the enrollee.

- To ask questions and receive complete information about the enrollee's health and treatment options, including specialty care, in a way they can understand
- To have a candid discussion of any appropriate or medically necessary treatment options for the enrollee's condition, regardless of cost or benefit coverage

- To take an active part in decisions about the enrollee's healthcare unless it is not in their best interest
- To agree to or decline treatment or therapy
  - If the enrollee declines, the provider or Humana Healthy Horizons must explain what could happen.
  - The provider adds a note in the enrollee's medical record.
- To be treated with respect, dignity, privacy, confidentiality, accessibility and be free from discrimination
- To have access to appropriate services and not be discriminated against based on health status, religion, age, gender or other bias
- To be sure others cannot hear or see the enrollee when receiving medical care
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease or revenge, as specified in federal laws
- To receive information in accordance with **42 CFR 438.10**
- To be furnished healthcare services in accordance with **42 CFR 438.206**
- To receive services from a participating Indian Health Service, Tribally-operated Facility/Program and Urban Indian Clinic (I/T/U) provider or an I/T/U PCP if they are part of Humana Healthy Horizons
- To receive help with the enrollee's medical records in accordance with applicable federal and state laws
- To be sure that the enrollee's medical records are kept private
- To ask for and receive one free copy of their medical records and to be able to ask that their health records be changed or corrected if needed
  - More copies are available to enrollees at cost.
  - Records will be retained for five years or longer as required by federal law.
- To agree to or decline having information about the enrollee given out unless Humana Healthy Horizons must provide it by law
- To receive all written enrollee information:
  - At no cost to the enrollee
  - In the prevalent non-English languages of enrollees in our service area
  - In other ways to help with the special needs of enrollees who have trouble reading the information for any reason
- To receive help from Humana Healthy Horizons and providers if the enrollee does not speak English or needs help to understand information
  - Enrollees can receive help free of charge.
- To receive help with sign language if the enrollee is hearing-impaired
- To be informed if a healthcare provider is a student and be able to refuse their care
- To be informed if care is experimental and be able to refuse to be part of the care
- To know that Humana Healthy Horizons must follow all federal, state and other laws about privacy that apply
  - This includes procedures for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth with parental notice or consent.
- If the enrollee is female, to be able to go to a woman's health provider in our network for covered woman's health services
- To file an appeal or grievance (complaint) or request a state fair hearing
  - Enrollees also can get help with filing an appeal or a grievance.
  - Enrollees can ask for a state fair hearing from Humana Healthy Horizons and/or Kentucky DMS.
- To contact the Office of Civil Rights at the following address with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services:

  **Office for Civil Rights**
  **Sam Nunn Atlanta Federal Center**
  Suite 16T70 62 Forsyth St., S.W.
  Atlanta, GA 30303-8909
  Phone: **800-368-1019**
  TTY: **800-537-7697**
  Fax: **202-619-3818**

- To receive information about Humana Healthy Horizons, its services, its providers, and enrollee rights and responsibilities
- To make advance directives, such as a living will (Please reference the Advance Medical Directives section of this manual.)
- To make recommendations to the Humana Healthy Horizons Enrollee Rights and Responsibility policy
- To be provided with out-of-network services, if Humana Healthy Horizons is unable to provide a necessary and covered service in our network
  - Humana Healthy Horizons covers these services for as long as the service is not provided in the Humana Healthy Horizons provider network.
  - If an enrollee is approved to go out-of-network, this is their right as an enrollee.
  - There is no cost to the enrollee.
- To be free to carry out their enrollee rights and know that Humana Healthy Horizons or its providers cannot hold this against them

Humana Healthy Horizons may not discriminate on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services in the receipt of health services.

Humana Healthy Horizons enrollees also are informed of the following responsibilities:
- Know your rights.
- Follow Humana Healthy Horizons and Kentucky Medicaid policies and procedures.
- Know about your service and treatment options.
- Take an active part in decisions about your personal health and care, and lead a healthy lifestyle.
- Understand as much as you can about your health issues.
- Take part in reaching goals that both you and your healthcare provider agree on.
- Let us know if you suspect healthcare fraud or abuse.
- Let us know if you are unhappy with us or one of our providers.
- If you file an appeal with us, put the request in writing.
- Use only approved providers.
- Report suspected fraud, waste or abuse.
- Keep scheduled doctor visits. Be on time. If you have to cancel, call 24 hours in advance.
- Follow the advice and instructions for care to which you have agreed with your healthcare providers.
- Always carry your enrollee ID card. Show it when receiving services.
- Never let anyone else use your enrollee ID Card.
- Connect with Humana Healthy Horizons to discuss care.
- Let us know of a name, address or phone number change, or a change in the size of your family.
- Let us and DCBS know about births and deaths in your family. The location of the nearest DCBS office is **available online**. You can also call the ombudsman toll-free at **800-372-2973**.
- Call your PCP after going to an urgent care center, after a medical emergency or after receiving medical care outside of Humana Healthy Horizons' service area.
- Let Humana Healthy Horizons and the DCBS know if you have other health insurance coverage.
- Provide information to Humana Healthy Horizons and your healthcare providers that is needed to care for you.

**Personally identifiable information and protected health information**

In the day-to-day business of patient treatment, payment and healthcare operations, Humana Healthy Horizons and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide how PII is appropriately protected when stored, processed and transferred in the course of conducting normal business. As a provider, you should be taking measures to secure your patients' data.

You also are mandated by HIPAA to secure all protected health information (PHI) related to your patients. There are many administrative, physical and technical controls you should have in place to protect all PII and PHI.

Here are some important places to start:
- Utilize a secure message tool or service to protect data sent by email.

- Have policies and procedures in place to address the protection of paper documents containing patient information, including secure storage, handling and destruction of documents.
- Encrypt all laptops, desktops and portable media such as CD-ROMs and USB flash drives that may potentially contain PHI or PII.

**Enrollee privacy**

The HIPAA Privacy Rule requires health plans and covered healthcare providers to develop and distribute a notice that provides a clear, user-friendly explanation of individuals' rights with respect to their personal health information, as well as the privacy practices of health insurance plans and healthcare providers.

Kentucky DMS provides a privacy notice to Medicaid recipients. Providers can access the **HIPAA Information** page online. The notice informs enrollees about how Kentucky DMS is legally required to protect the privacy of enrollee data.

As a provider, please follow the HIPAA regulations and make only reasonable and appropriate uses and disclosures of protected health information for treatment, payment and healthcare operations.

**Enrollee consent to share health information**

Consent is the enrollee's written permission to share their information. Not all disclosures require the enrollee's permission. The following are consent requirements that pertain to sensitive health information (SHI) and SUD treatment:

- SHI is defined by the state (e.g., HIV/AIDS, mental health, sexually transmitted diseases).
- **SUD 42 CFR Part 2** pertains to federal requirements that apply to all states.

While all enrollee data is protected under the HIPAA Privacy Rules, Part 2 provides more stringent federal protections to protect individuals with SUDs who could be subject to discrimination and legal consequences in the event their information is inappropriately used or disclosed. The state requirements provide more stringent protections for the sharing of certain information determined to be SHI.

When consent is on record, Humana Healthy Horizons displays all enrollee information on Availity Essentials at **Availity.com** and any health information exchanges. Please explain to your patients that if they do not consent to let Humana Healthy Horizons share this information, the providers involved in their care may not be able to effectively coordinate their care. When an enrollee does not consent to share this information, a message displays on the provider portal to indicate that all of the enrollee's health information may not be available to all providers.

## Quality improvement

Humana Healthy Horizons has a comprehensive quality improvement program that encompasses clinical care, preventive care, population health management and administrative functions. To receive a written copy of Humana Healthy Horizons' quality improvement program and its progress toward goals, please submit a request to the following address:

**Humana Healthy Horizons in Kentucky**
Attention: Quality Improvement
101 E. Main St.
Louisville, KY 40202

**Quality management activities**

Participating providers agree to assist Humana Healthy Horizons with its performance of the following quality management activities:

- Enrollee medical records reviews—Conducted to meet requirements of accrediting agencies and federal and state law requirements
  - Quarterly, Humana Healthy Horizons reviews a sample of clinical records for our enrollees.
  - Humana Healthy Horizons does not review all records and is not responsible for assuring the adequacy or completeness of records.
  - If a provider fails their quarterly audit, that provider will be reaudited in six months.
  - Provider Relations representatives are engaged to provide education and training when a provider fails a quarterly audit.
- If the provider fails multiple quarters in a row, this may result in a required corrective action, termination of contract and/or reporting of the violation to appropriate regulatory and/or law enforcement authorities.

- Compliance with confidentiality requirements of enrollee medical records will be addressed with providers and education provided as appropriate.
- Areas identified for improvement are tracked and corrective actions taken as indicated. The effectiveness of corrective actions are monitored until problem resolution occurs. Reevaluations will occur to ensure that improvement is sustained.
- In the event that corrective actions are imposed on a healthcare provider or third party, Humana Healthy Horizons monitors and/or audits the healthcare provider or third party to confirm that corrective actions were implemented. Monitoring and auditing following implementation of the corrective action also occurs, as appropriate, to facilitate effective corrective actions.

- Humana Healthy Horizons may conduct medical record reviews to identify gaps in care for our enrollees. HEDIS measures now include care coordination measures for enrollees transitioning from a hospital or emergency department to home for which hospitals and providers have additional responsibilities. In addition to medical record reviews, information for HEDIS is gathered administratively via claims, encounters and submitted supplemental data. There are two primary routes for supplemental data:
  - Nonstandard supplemental data involves directly submitted, scanned images (e.g., PDF documents) of completed attestation forms and medical records. Nonstandard data also can be accepted electronically via a proprietary Electronic Attestation Form (EAF) or Practitioner Assessment Form (PAF). Submitted nonstandard supplemental data is subject to audit by a team of nurse reviewers before ending a HEDIS improvement opportunity.
  - Standard supplemental data flows directly from one electronic database (e.g., population health system, EMR) to another without manual interpretation. Therefore, standard supplemental data is exempt from audit consideration. Standard supplemental data can be accepted via HEDIS-specific custom reports extracted directly from the provider's EMR or population health tool and is submitted to Humana Healthy Horizons via either secure email or file transfer protocol (FTP) transmission. We also accept lab data files via the same methods. Humana Healthy Horizons partners with various EMRs to provide enrollee summaries and detail reports and to automatically retrieve scanned charts.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)—The CAHPS survey includes several measures that reflect enrollee satisfaction with the provider's care and service.
  - Each year surveys are sent to our enrollees that ask multiple questions of how the provider and Humana Healthy Horizons are performing.
- Occurrences and adverse events reporting—Unexpected occurrences and adverse events involving enrollees are reported to the Quality Improvement department by providers, precertification nurses and care managers. Cases are reviewed according to Humana Healthy Horizons' Quality Management guidelines and peer-review process, as required by law and accrediting agencies.
- Enrollee complaints—Enrollee complaints and grievances pertaining to quality of care and concerns may be referred to the Quality Operations Compliance and Accreditation department for review.
- Humana Healthy Horizons participates in the following Kentucky DMS requirements:
  - Maintain a health information system that collects, integrates, analyzes and reports data necessary to implement the quality improvement program
  - Initiate performance improvement projects (PIPs) that address those areas identified as healthcare priorities for our enrollees or topics mandated by Kentucky DMS

**Quality improvement requirements**

Humana Healthy Horizons monitors and evaluates provider quality, appropriateness of care and service delivery to enrollees using the following methods:

- PIPs—Ongoing measurements and interventions that seek to demonstrate significant improvement to the quality of care and service delivery sustained over time, in both clinical care and nonclinical care areas, which have a favorable effect on enrollee health outcomes and enrollee satisfaction
- Enrollee medical record reviews—Medical record reviews to evaluate documentation patterns of providers and adherence to enrollee medical record documentation standards; Medical records also may be requested when investigating complaints of poor quality or service or clinical outcomes.
  - Refer to the External Quality Reviews section below for more information on medical record reviews.
- Performance measures—Data collected on patient outcomes as defined by HEDIS or otherwise defined by NCQA

- Surveys—CAHPS, provider satisfaction, behavioral health surveys and special surveys implemented to support quality/performance improvement initiatives
- Peer review—Review of providers' practice methods and patterns to determine appropriateness of care

## Access standards

The quality improvement program includes evaluation of the availability, accessibility and acceptability of services rendered to enrollees by participating providers.

Please keep in mind the following access standards for differing levels of care. Participating providers are expected to have procedures in place to see enrollees within these time frames and to offer office hours to their Humana Healthy Horizons-covered patients that are at least the equivalent of those offered to all other patients. Humana Healthy Horizons will monitor appointment time compliance through the use of secret shopper surveys in accordance with contractual requirements.

Enrollees should be triaged and provided appointments for care within the time frames outlined in the following tables:

**PCPs**

| Patients with: | Should be seen: |
|---|---|
| **Emergency needs** | Immediately on presentation, 24 hours a day, seven days a week |
| **Urgent care** | Not to exceed 48 hours from date of an enrollee's request |
| **Routine care needs** | Not to exceed 30 days from date of an enrollee's request |

**Non-PCP specialists**

| Patients with: | Should be seen: |
|---|---|
| **Emergency needs** | Immediately on presentation, 24 hours a day, seven days a week |
| **Urgent care** | Not to exceed 48 hours from date of an enrollee's request |
| **Routine care needs** | Not to exceed 30 days from date of an enrollee's request |

**Behavioral health providers**

| Patients with: | Should be seen: |
|---|---|
| **Care for non-life-threatening emergencies** | Must be provided within six hours, crisis stabilization |
| **Urgent care** | Within 48 hours |
| **Initial visit or routine office visit** | Shall not exceed 10 business days |
| **Post discharge from an acute psychiatric hospital** | Within seven days |

Providers must contact enrollees who have missed an appointment within 24 hours to reschedule.

Other referrals may not exceed 60 days.

General vision, lab and X-ray wait times must not exceed 30 days for regular appointments and 48 hours for urgent care.

An enrollee should be seen as expeditiously as the enrollee's condition warrants based on severity of symptoms. If a provider is unable to see the enrollee within the appropriate time frame, then Humana Healthy Horizons facilitates an appointment with a participating provider or a nonparticipating provider when necessary.

**PCP after-hours availability**

The PCP provides or arranges coverage of services, consultation or approval for referrals 24 hours a day, seven days a week by Medicaid-enrolled providers who accept Medicaid reimbursement. This coverage should consist of an answering service, call forwarding, provider call coverage or other customary means approved by Kentucky DMS.

The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hours coverage must be accessible using the medical office's daytime telephone number. The PCP arranges for coverage of primary care services during absences due to vacation, illness or other situations that require the PCP to be unable to provide services. A Medicaid-eligible PCP must provide coverage.

PCPs must maintain formalized relationship with other PCPs to refer enrollees for after-hours care, during certain days, for certain services, and for other reasons to extend the hours of services of their practice. Humana Healthy Horizons ensures PCPs implement the following acceptable after-hours phone arrangements and that the unacceptable arrangements are not implemented as defined below:

Acceptable after-hours phone arrangements

- The office phone is answered after hours by an answering service that can contact the PCP or another designated provider, and the PCP or designee is available to return the call within 30 minutes.
- The office phone is answered after hours by a recording directing the enrollee to call another number to reach the PCP or another provider whom the provider designated to return the call within 30 minutes.
- The office phone is transferred after hours to another location where someone answers the phone and is able to contact the PCP or another designated provider within 30 minutes.

Unacceptable after-hours phone arrangements

- The office phone is only answered during office hours.
- The office phone is answered after hours by a recording that tells enrollees to leave a message.
- The office phone is answered after hours by a recording that directs enrollees to go to the emergency room for any services needed.
- After-hours calls are returned later than 30 minutes.

## Preventive guidelines and clinical practice guidelines

These clinical treatment protocols are systematically developed statements that help providers and enrollees make decisions regarding appropriate healthcare for specific clinical circumstances or for specific age ranges.

We strongly encourage providers to use these guidelines and to consider these guidelines whenever they promote positive outcomes for Humana Healthy Horizons-covered patients.

The use of these guidelines allows Humana Healthy Horizons to measure the impact of the guidelines on outcomes of care. Humana Healthy Horizons monitors provider implementation of guidelines by analyzing claim, pharmacy and utilization data.

Preventive health guidelines and clinical practice guidelines are distributed to all new and existing providers through the following formats:

- Provider manual updates
- Provider newsletters
- **Provider website**

Providers also receive preventive health and clinical practice guidelines through the Care Management department or from their **Provider Relations representative**.

## Quality Assurance and Performance Improvement (QAPI) program

Humana Healthy Horizons has a QAPI program that includes the following:

- PIPs
- Over- and underutilization measures
- Annual analysis of plan demographics, including clinical, geographical and cultural data points, to identify high-risk populations, areas of network need, enrollee education opportunities and performance improvement opportunities
- Assessment of access and availability of network providers, including after-hours availability of PCPs
- Assessment of quality and appropriateness of care furnished to children with special healthcare needs
- Continuity and coordination of care
- HEDIS measurement
- CAHPS review

- Annual measurement of effectiveness review of the QAPI

We welcome healthcare providers' input regarding our QAPI program. Feedback can be provided in writing to the following address:

**Humana Healthy Horizons in Kentucky**
Attention: Quality Improvement
101 E. Main St.
Louisville, KY 40202

## External quality reviews

Through Humana Healthy Horizons' contract with the commonwealth of Kentucky, Humana Healthy Horizons is required to participate in periodic medical record reviews. The commonwealth of Kentucky retains an external quality review organization (EQRO) to conduct medical record reviews for Humana Healthy Horizons enrollees.

**Provider maintenance of medical records**

Humana Healthy Horizons ensures PCPs maintain a primary medical record for each enrollee that contains sufficient medical information to ensure continuity of care. The medical record should be signed by the provider of service. The enrollee's medical record is the property of the provider who generates the record. In addition:

- Humana Healthy Horizons requires that each enrollee or their representative is entitled to one free copy of their medical record.
  - Additional copies are made available to enrollees at cost.
- Medical records generally should be preserved and maintained by the provider for a minimum of five years unless federal requirements mandate a longer retention period (i.e., immunization and tuberculosis records are required to be kept for a person's lifetime).

Complete medical records include:

- Medical charts
- Prescription files
- Hospital records
- Provider specialist reports
- Consultant and other healthcare providers' findings
- Appointment records
- Other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of services

Humana Healthy Horizons periodically requests enrollee medical records as part of our provider monitoring as described in the Enrollee Medical Record Review section. Humana Healthy Horizons realizes that supplying medical records for review requires your staff's valuable time; your cooperation with our requests and associated timelines is appreciated. Humana Healthy Horizons offers the following suggestions to ensure complete and accurate documentation of enrollee services:

- Use legible handwriting for paper medical records.
- Consider dictated notes, which can improve comprehension of medical records while reducing the chance of misinterpretation.
- Include the patient's name on front and back of every page of the medical record.
- Initial and date lab results in the medical record to indicate review by a provider.
- Record all patient visit dates and sign all chart entries.
- Consider using preprinted forms to document all aspects of comprehensive services, such as EPSDT exams.

**Standards for enrollee medical records**

The following standards apply for enrollee medical records:

- Enrollee/patient identification information on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, language spoken, and guardianship information
- Date of data entry and date of encounter
- Provider name

- Adverse reactions and all known allergies noted in a prominent location
- Past medical history, including serious accidents, operations and illnesses
  - For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (e.g., documentation of chicken pox).
- Identification of current problems
- Consultation, laboratory and radiology reports with the ordering provider's initials or other documentation indicating review
- Documentation of immunizations pursuant to 902 KAR 2:060
- Identification and history of nicotine, alcohol or substance use
- Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health, pursuant to 902 KAR 2:020
- Follow-up visits provided secondary to reports of emergency room care
- Hospital discharge summaries
- Advance medical directives (for adults)
  - PCPs have the responsibility to discuss advance medical directives with adult enrollees at the first medical appointment and chart that discussion in the enrollee's medical record.
- All written denials of service and the reason for the denial
- Record legibility to at least a peer of the writer
  - Any record judged illegible by one reviewer will be evaluated by another reviewer.

An enrollee's medical record must include the following minimal detail for individual clinical encounters:
- History and physical examination for presenting complaints, containing relevant psychological and social conditions affecting the patient's medical/ behavioral health, including mental health and SUD status
- Unresolved problems, referrals and results from diagnostic tests, including results and/or status of preventive screening services (e.g., EPSDT) from previous visits
- Plan of treatment, including:
  - Medication history, medications prescribed, including the strength, amount, directions for use, and refills
  - Therapies and other prescribed regimen
  - Follow-up plans including consultation, referrals and directions, including time to return

An enrollee's medical record must include, at a minimum, the following for hospital and mental hospital visits:
- Enrollee's name
- Provider's name
- Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission
- The plan of care as required under 42 C.F.R. 456.172 (mental hospitals) or 42 C.F.R. 456.70 (hospitals)
  - Initial and subsequent continued-stay review dates described under 42 C.F.R. 456.233 and 42 C.F.R. 465.234 (for mental hospitals) and 42 C.F.R. 456.128 and 42 C.F.R. 456.133 (for hospitals)
- Reasons and plan for continued stay if applicable
- Other supporting material
- For non-mental hospitals only, the date of operating room reservation and the justification of emergency admission, if applicable

**Medical record reviews**

As stated above, Humana Healthy Horizons performs quarterly audits of randomly selected enrollee medical records. Periodically you may receive requests for enrollee medical record copies. Your contract with Humana Healthy Horizons requires that you furnish enrollee medical records to us for this purpose. Enrollee medical record reviews are a permitted disclosure of an enrollee's PHI in accordance with HIPAA. The record reviewers protect enrollee information from unauthorized disclosure as set forth in the contract and enforce all HIPAA guidelines. We will continue sharing the results of these studies and work in partnership with you to achieve the best healthcare possible for our enrollees.

Humana Healthy Horizons monitors a provider's actions to ensure they comply with Kentucky DMS and Humana Healthy Horizons policies, including:
- Maintain continuity of the enrollee's healthcare

- Maintain a current medical record for the enrollee, including documentation of all PCP and specialty care services
- Document all care rendered in a complete and accurate medical record that meets or exceeds Kentucky DMS specifications

Humana Healthy Horizons has a process to systematically review provider enrollee medical records to ensure compliance with the medical records standards outlined in the contract and described above.

After completing the enrollee medical record reviews, Humana Healthy Horizons and the Provider Relations representative institute improvement actions when standards are not met by the provider. The medical records audit process also assesses the effectiveness of practice site follow-up plans to increase compliance with established medical records standards and goals. Humana Healthy Horizons developed methodologies for assessing performance/compliance to medical record standards for providers. Audit activity, at a minimum, should:

- Demonstrate the degree to which providers comply with clinical and preventative care guidelines
- Allow for the tracking and trending of individual and network provider performance over time
- Include mechanisms and processes that allow for the identification, investigation and resolution of quality of care concerns
- Include mechanisms for detecting instances of overutilization, underutilization and misuse

## Provider performance and profiling

As a function of UM oversight responsibilities, Humana Healthy Horizons monitors over- and underutilization of medical services. Provider profiling is performed periodically to measure utilization of common inpatient and outpatient services, such as preventive services and pharmacy utilization. Summary reports for these measures are available to individual providers on request, and routine periodic reporting.

If a provider is found to be performing below minimum care standards for participation with Humana Healthy Horizons, this information is shared with the provider so they can make positive changes in practice patterns. We are committed to working with our providers to develop an action plan for improvement for those who do not meet standards. Further action may include on-site assessment, auditing medical care at specific intervals, disseminating comparative data or standards of care, meeting with providers, reporting deficiencies to appropriate authorities, or participation termination with Humana Healthy Horizons.

## Fraud and abuse policy

Providers must incorporate a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse. Contracted providers agree to educate their employees about the False Claims Act prohibition on submitting false or fraudulent claims for payment, penalties for false claims and statements, whistleblower protections, and each person's responsibility to prevent and detect FWA.

Humana Healthy Horizons and Kentucky DMS should be notified immediately if a provider or their office staff:

- Is aware of any provider that may be billing inappropriately (e.g., falsifying diagnosis codes and/or procedure codes, or billing for services not rendered)
- Is aware of an enrollee intentionally permitting others to use their enrollee ID card to obtain services or supplies from the plan or any network provider
- Is suspicious that someone is using another enrollee's ID card
- Has evidence that an enrollee knowingly provided fraudulent information on their enrollment form that materially affects the enrollee's eligibility

Providers may provide the above information via an anonymous phone call to Humana Healthy Horizons' special investigations hotline at **800-614-4126**. All information is kept confidential.

Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Humana Healthy Horizons ensures no retaliation against callers as Humana Healthy Horizons has a zero-tolerance policy for retaliation or retribution against all persons who report suspected misconduct. Providers also may call Humana Healthy Horizons at **800-444-9137** and Kentucky CHFS at **800-372-2970**.

In addition, providers may use the following contacts for reporting fraud, waste, and abuse:

**Telephonic:**

- SIU Direct Line: **800-558-4444**, ext. 1500724 Monday through Friday, 8 a.m. to 5:30 p.m. Eastern time
- SIU Hotline: **800-614-4126** available 24 hours a day, 7 days a week
- Ethics Help Line: **877-5-THE-KEY (877-584-2539)**

**Email:**

SIUReferrals@humana.com or ethics@humana.com

**Web:**

Ethics Helpline

## Credentialing and recredentialing

**CAQH application**

Humana Healthy Horizons is a participating organization with the Council for Affordable Quality Healthcare (CAQH). Providers can confirm Humana Healthy Horizons has access to their credentialing application by completing the following steps:

- Sign in to the CAQH website using your account information.
- Select the Authorization Tab.
- Confirm Humana Healthy Horizons is listed as an authorized health plan. If it isn't, please check the authorized box to add.

Providers must include their CAQH provider ID number when submitting credentialing documents. It is essential that all documents are complete and current. Include copies of the following documents:

- Current malpractice insurance face sheet
- A current Drug Enforcement Administration (DEA) certificate
  - All buprenorphine prescribers must have an "X" DEA number.
- Explanation of all lapses in work history of more than six months
- CLIA certificate, as applicable
- Copy of collaborative practice agreement between an Advanced Practice Registered Nurse (APRN) and supervising provider
- Educational Commission for Foreign Medical Graduates (ECFMG) accreditation if a foreign medical degree is held

Failure to submit a complete application may result in a delay in our ability to complete or begin the credentialing process.

Humana Healthy Horizons conducts credentialing and recredentialing activities utilizing the guidelines established by the Kentucky DMS, CMS and NCQA. Humana Healthy Horizons credentials and recredentials all licensed independent providers, including facilities and non-physicians, with whom it contracts and who fall within its scope of its authority and action. Through credentialing, Humana Healthy Horizons verifies the qualifications and performance of providers. A senior medical director is responsible for oversight of the credentialing and recredentialing program.

All providers requiring credentialing should complete the credentialing process prior to the provider's contract effective date, except where required by state regulations. Additionally, a provider will only appear in the provider directory once credentialing is complete.

You can submit a completed CAQH application via:

**Humana Healthy Horizons in Kentucky**
Attention: Credentialing
101 E. Main St.
Louisville, KY 40202
Fax: **502-508-0521**
Email: CredentialingInquiries@Humana.com

**Provider credentialing and recredentialing**

All providers appearing in the Provider Directory are subject to credentialing and recredentialing. Providers within the scope of credentialing for Kentucky Medicaid include:

- Medical and osteopathic doctors
- Oral surgeons
- Chiropractors
- Podiatrists
- Nurse practitioners
- Physician assistants
- Dentists
- Optometrists
- Audiologists
- Other licensed or certified practitioners, including physician extenders who act as PCPs or those who appear in the Provider Directory

Behavioral health practitioners:

- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral- or masters-level psychologists who are state certified or licensed
- Masters-level clinical social workers who are state certified or licensed
- Masters-level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed
- Other behavioral health specialists who are licensed, certified or registered by the state to practice independently, including licensed art therapists

The following elements are used to assess practitioners for credentialing and recredentialing:

- Signed and dated credentialing application, including supporting documents
- Active and unrestricted license in the practicing state issued by the appropriate licensing board
- Previous five-year work history
- Current DEA certificate and/or Kentucky narcotics registration, as applicable
- Education, training and experience, current and appropriate to the scope of practice requested, including:
  - Successful completion of all pertinent training programs
  - For M.D.s and D.O.s, successful completion of residency training pertinent to the requested practice type
  - For dentists and other providers where special training is required or expected, successful completion of training program
  - Board certification, as applicable
  - Current malpractice insurance coverage at the minimum amount in accordance with Kentucky laws
- Good standing with:
  - Medicaid agencies
  - Medicare program
  - Health and Human Services-Office of Inspector General (HHS-OIG)
  - General Services Administration (GSA, formerly Excluded Parties List System [EPLS])
- Active and valid Kentucky Medicaid ID number
- Active hospital privileges, as applicable
- NPI, as verifiable via the National Plan and Provider Enumerator System (NPPES)
- Quality of care and practice history as judged by:
  - Medical malpractice history
  - Hospital medical staff performance
  - Licensure or specialty board actions or other disciplinary actions, medical or civil
  - Lack of enrollee grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall enrollee satisfaction
  - Other quality of care measurements/activities

**Organizational credentialing and recredentialing**

The organizational providers to be assessed during credentialing and recredentialing include:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing ambulatory surgery centers
- Hospice providers
- Behavioral health facilities providing mental health or SUD services in an inpatient, residential or ambulatory setting
- Dialysis centers
- Physical, occupational therapy and speech language pathology (PT/OT/SLP) facilities
- Rehabilitation hospitals (including outpatient locations)
- Diabetes education
- Portable X-ray suppliers
- Rural health clinics and federally-qualified health centers
- Free-standing birth centers

The following elements are assessed for organizational providers:

- Good standing with:
  - Medicaid agencies
  - Medicare program
  - HHS-OIG
  - GSA, formerly EPLS
- Active and valid Kentucky Medicaid ID number
- Completed and passed an on-site survey conducted by at least one of the following entities, as applicable:
  - Approved accrediting body
  - CMS, letter of certification or report of survey, not more than 3 years old
  - State review, evidence of review not more than 3 years old
- Copy of facility's state license, as applicable
- CLIA certificates are current, as applicable
- Current malpractice insurance coverage at the minimum amount in accordance with Kentucky laws
- Completed, signed and dated application

The organization will be informed of the credentialing committee's decision within 60 business days of the committee meeting. Organizational providers are reassessed at least every three years.

**Provider recredentialing**

Network providers, including individual and organizational providers, are recredentialed at least every three years. As part of the recredentialing process, Humana Healthy Horizons considers information regarding performance to include complaints, safety and quality issues collected through the quality improvement program. Additionally, information regarding adverse actions is collected from the National Practitioner Data Bank (NPDB), Medicare and Medicaid sanctions, the CMS Preclusion list, the HHS-OIG, GSA (formerly EPLS), and limitations on licensure.

**Provider rights**

- Providers have the right to review, on request, information submitted to support their credentialing application to the Humana Healthy Horizons Credentialing department. All submitted information is kept secured and confidential. Access to electronic credentialing information is password-protected and limited to staff that require access for business purposes.
- Providers have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the Credentialing department prior to presentation to the credentialing committee. If information obtained during the credentialing or recredentialing process varies substantially from the application, the provider is notified and given the opportunity to correct information prior to presentation to the credentialing committee.
- Providers have the right to be informed of their credentialing or recredentialing application status by submitting written request to the Credentialing department.

**Provider responsibilities**
Network providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria.

Humana Healthy Horizons initiates immediate action in the event that participation criteria are no longer met. Network providers are required to inform Humana Healthy Horizons of changes in status, including being named in a medical malpractice suit; involuntary changes in hospital privileges, licensure or board certification; an event reportable to the NPDB; and federal, state or local sanctions or complaints.

**Delegation of credentialing/recredentialing**
Humana Healthy Horizons only enters into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated is accredited by NCQA for these functions or utilizes a NCQA-accredited credential verification organization. They also must successfully pass a pre-delegation audit demonstrating compliance with NCQA federal and state requirements. A pre-delegation audit must be completed prior to entering into a delegated agreement.
All preassessment evaluations are performed using current NCQA and regulatory requirements. The following, at a minimum, are included in the review:

- Credentialing and recredentialing policies and procedures
- Credentialing and recredentialing committee meeting minutes from the previous year
- Credentialing and recredentialing file review

Delegates must be in good standing with Medicaid and CMS. Monthly reporting is required from the delegated entity, which is defined in an agreement between both parties.

**Reconsideration of credentialing/recredentialing decisions**
Humana Healthy Horizons' credentialing committee may deny a provider's request for participation based on credentialing criteria. The credentialing committee must notify a provider of a denial based on credentialing criteria and provide the opportunity to request reconsideration of the decision within 30 days of the notification. Reconsideration opportunities are available to a provider if they are affected by an adverse determination. To submit a reconsideration request, please mail a reconsideration request to the senior medical director. A reconsideration request must be in writing and include all additional supporting documentation.

Mail a reconsideration request to:
**Humana Healthy Horizons in Kentucky**
Attn: Jennifer Moncrief, M.D., Regional Medical Director
101 E. Main St.
Louisville, KY 40202

On reconsideration, the credentialing committee may affirm, modify or reverse its initial decision. Humana Healthy Horizons notifies the applicant in writing within 60 days of the credentialing committee's reconsideration decision. Reconsideration denials are final unless the decision is based on quality criteria, and providers have the right to request a state fair hearing. Providers who were denied are eligible to reapply for network participation once they meet the minimum Humana Healthy Horizons credentialing criteria. Applying providers do not have appeal rights. However, they may submit additional documents to the address above for reconsideration by the credentialing committee.