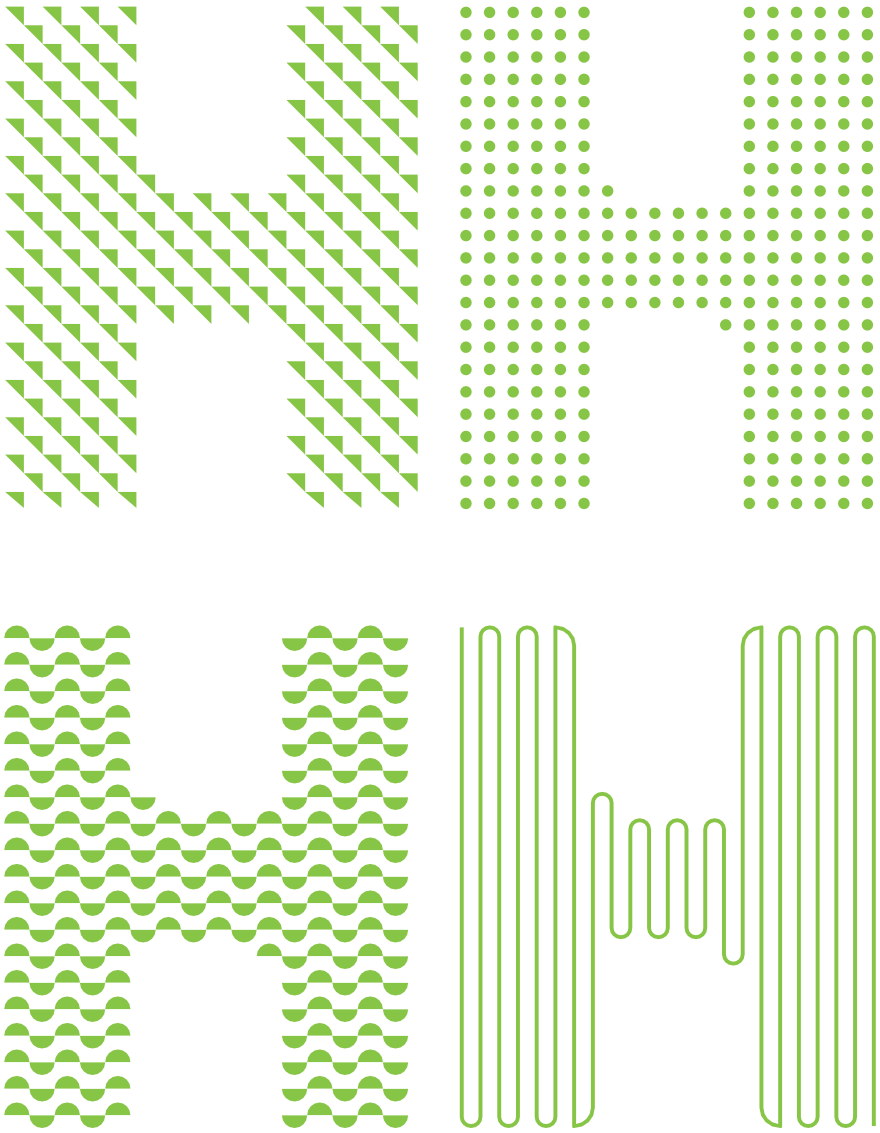

2025 Provider Manual

HUMANA HEALTHY HORIZONS IN KENTUCKY

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

572302KY1024 (HUMP572302) KYHLW6TEN

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Welcome

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

We strive to collaborate 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 members.

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 members. We focus on prevention and partnering with local providers to offer the services our members need to be healthy.

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

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

- New members
- Existing members
- New providers
- Existing providers

About us

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

- Care management and care transitions programs
- Analytical tools to identify members 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 members are addressed
- Access to behavioral health services that includes crisis intervention and a dedicated hotline
- An award-winning history in member services, training, clinical programs and customer satisfaction
- The ability to scale, innovate and provide ongoing support to our extensive provider network

Humana Healthy Horizons makes a difference

Humana Healthy Horizons brings a history of innovative programs and collaborations to ensure our members 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 members to get the healthcare they need when they need it. Through community-based partnerships and services, we help our members successfully navigate complex healthcare systems.

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

Our services include:

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

In addition, our care management programs include the following:

- Case management
- On-site case management (clinics and facilities)
- Emergency department diversion
  - Identification of members 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

About this manual

Color coding and font variations are used to denote different information throughout this manual, as follows:

- **Internal references** to other parts of this provider manual are denoted in bold magenta font.
- **Contact information** that is available in greater detail in this manual's phone book is denoted in bold eggplant font. **Please note: You can use the *Alt and left arrow* keys together to return to the section you were reading.**
- **Hyperlinks** are denoted in bold, underlined and navy font.

Major updates to the 2025 provider manual

- Entire manual has been reorganized into chapters
- Centralized phone book added with contact information
- Practitioner Assessment Form, Humana's Care Profile application and Medical Record Management applications added to Availity Essentials™ overview
- Health education section added
- Member identification card images updated
- New member kit contents description
- Equitable population health management description
- Cultural competency terminology changed to read, "cultural humility, health equity and implicit bias"
- Arcadian removed as virtual/telehealth services vendor
- MDLIVE® added as virtual urgent care service vendor
- Special Investigations Unit (SIU) direct line hours of operation updated to 10 a.m. – 6 p.m., Eastern time
- Service Fund via Availity Essentials added for viewing/printing a provider's member list

- Language added to PCP roles and responsibilities chapter
- SafeLink® removed as smartphone services vendor
- Required information for filing member grievances updated
- Information added about preauthorization for medications administered in the provider setting
- Updates made to the pharmacy lock-in program section
- Updates made to the retrospective review section
- Provider relations representatives added as a point of contact for questions regarding clearinghouse rejections
- Claim accuracy and completeness issues removed from list of features in Availity Essentials
- Details updated in electronic data interchange (EDI) clearinghouses section
- Updates throughout code editing and payment policies section
- Certified Community Behavioral Health Clinics added as a provider type in fee schedules section
- Prenatal risk assessment form (PRAF) removed from prenatal care management section and replaced with a notification of pregnancy (NOP) form
- Material added to member rights and responsibilities section
- Material added to medications administered in the provider setting regarding current medical and pharmacy coverage policies
- Material added to access to UM staff section

Chapter 1: Humana Healthy Horizons in Kentucky

Humana Healthy Horizons provider relations representatives

Humana Healthy Horizons 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** conducts a required yearly on-site visit to PCP offices to ensure compliance and provide education that includes, but is not limited to, the following areas:

- Access and availability standards
- Privacy practices
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) policies and procedures
- Patient rights and responsibilities
- Provider resources
- Cultural humility, health equity and implicit bias
- Case management programs
- Encounter submissions
- Grievance and appeals processes
- **Kentucky Health Information Exchange (KHIE)** participation
- **Vaccines for Children program**
- Member disenrollment processes

More information about your assigned **provider relations representative** is available on the **Kentucky Medicaid Documents and Resources website**. If you are unable to determine who your representative is, please contact **Provider Relations**.

Medicaid claims-related inquiries can be sent to **Claims Research and Resolution Team** via email. Please copy your **provider relations representative** on the inquiry.

Communicating with Humana Healthy Horizons

Humana Healthy Horizons can be reached via a variety of methods as outlined in this manual's phone book. General inquiries can be directed to **Provider Services** or **Member Services**.

Availity Essentials

Humana Healthy Horizons uses **Availity Essentials** to supply providers with member references and claim data for multiple payers using a single sign-in. This includes access to the following:

- Eligibility and benefits
- Referrals and authorization
- Claim status
- Claim submission
- Submission of disputes and appeals
- Remittance advice
- Member summary
- Overpayment
- Electronic remittance advice (ERA)/electronic funds transfer (EFT)
- The Practitioner Assessment Form (PAF), a comprehensive health assessment form healthcare providers can use to help document vital patient information during a face-to-face physical examination
- Humana's Care Profile application, which enables providers to view attributed members' contact information, assessments and care plans
- The Medical Record Management application, which enables seamless sharing of medical record information, including admission, discharge and transfer (ADT) data in near real time
- Reporting

Humana Healthy Horizons' 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.

To learn more, please review the **Availity Essentials registration information** or contact **Availity Essentials**.

Compliance and ethics

Humana Healthy Horizons serves a variety of constituencies, including members, providers, government regulators and community partners. We serve all constituencies by working together with honesty, respect and integrity. That said, we are all responsible for complying with all applicable state and federal regulations along with applicable Humana Healthy Horizons policies and procedures.

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

- Formalizes Humana Healthy Horizons' commitment to honest communication within the company and within the community, inclusive of our providers, members 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 members 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 reach out to **Provider Services**.

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

Accreditation

Humana Healthy Horizons holds a strong commitment to quality. We demonstrate our commitment through programs based on national standards, when applicable. Humana Healthy Horizons 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 provider website**. Our provider website includes a wealth of information, including:

- 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 contact **Provider Services**.

Health education

We distribute health information to our Humana Healthy Horizons members through a variety of communication methods, including easy-to-read newsletters, brochures, phone calls and personal interaction. We also send preventive care reminder messages to members via mail and automated outreach messaging.

Chapter 2: Member eligibility and enrollment

Medicaid eligibility

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

The commonwealth of Kentucky provides eligibility information for members assigned to Humana Healthy Horizons daily via the 834 file. Eligibility begins on the first day of each calendar month for members joining Humana Healthy Horizons, with 2 exceptions:

- Newborns born to an eligible mother are eligible at birth.
- In accordance with 45 C.F.R. 233.100, members who meet the definition of unemployed are eligible on the date they are deemed unemployed.

Medicaid redetermination process

Humana Healthy Horizons members must complete the Medicaid eligibility redetermination process to ensure they do not lose their Medicaid coverage and benefits. Kentucky DCBS sends members a form by mail when it is time to initiate the redetermination process. Humana Healthy Horizons also reminds members to complete the redetermination process or risk losing their coverage and benefits.

If a member asks about completing the redetermination process, please advise that it is required to maintain Medicaid coverage.

Members can complete the process electronically, by mail, by phone or through their local **DCBS county office**:

Modality	Directions
Electronically	Members who applied for Medicaid online should complete the redetermination process on the **kynect website**.
By mail or phone	Members can complete the Renewal Form for Medical Coverage (sent to Kentucky Medicaid recipients) and mail it to the **Cabinet for Health and Family Services (CHFS) Division of Family Support (DFS)**.
In person	Members can visit their local **DCBS county office**. **DCBS county office locations** are available online.

Newborn enrollment

When the newborn's mother is a member with a Humana Healthy Horizons Medicaid plan, the newborn's coverage begins on their date of birth. Newborns of a nonpresumptive member are deemed eligible for Medicaid and automatically enrolled as an individual member for 60 days. The delivering hospital is required to enter the birth record into the birth record system, Kentucky's Child Hearing Immunization and Laboratory Data (KY-CHILD). This information is used to automatically enroll the newborn deemed eligible within 24 hours of birth. Newborns then appear on the PCP's member eligibility list after they are added to the Humana Healthy Horizons system. Providers must use the newborn's Medicaid ID on any claim submitted for that newborn.

Please refer to the verify eligibility section of this manual for instructions.

Automatic renewal

If a Humana Healthy Horizons member loses Medicaid eligibility but becomes eligible again within 2 months, they are automatically reenrolled in Humana Healthy Horizons and assigned to the same PCP, if possible.

Humana Healthy Horizons and the Kentucky CHFS Department for Medicaid Services (Kentucky DMS) remind all providers to check

a patient's eligibility via **KYHealthNet** before providing services. In instances when **KYHealthNet** shows the person presenting for services is incarcerated and the status is incorrect:

- Advise the member to complete the **Incarceration Status Correction form** and fax it to **Member Services**.
- Your patient can update their eligibility through their **kynect website** account.
- You can call **Kentucky CHFS provider services** to report the error.

Member ID cards

All new Humana Healthy Horizons members receive a Humana member identification (ID) card. A new card is issued only when the information on the card changes, if a member loses a card or if a member requests an additional card.

The member ID card is used to identify a Humana Healthy Horizons member; it does not guarantee eligibility or benefits coverage. Members may disenroll from Humana Healthy Horizons and retain their previous ID card. Likewise, members may lose Medicaid eligibility at any time. Therefore, it is important to verify member eligibility prior to every service.

Please refer to the verify eligibility section of this manual for instructions.

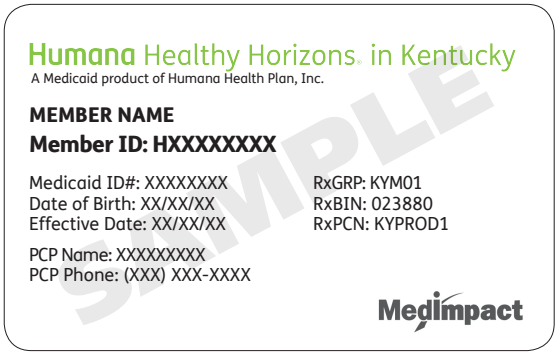
Information included on the member ID card:

- Member's name
- Member's date of birth
- Member's Humana Healthy Horizons member ID number
    - Use this number on claims.
- Member's Medicaid ID number
    - Please do not use this number to bill Humana Healthy Horizons.
- Member's PCP/clinic name
    - Members choose a participating provider to be their PCP. If a choice is not made, a PCP is assigned where appropriate.
- **Member Services** contact information
- **Nurse Advice Line**
- **Behavioral Health Crisis Line**
    - Members can call this hotline 24 hours a day, 7 days a week, for mental health or substance use disorder (SUD) services.
- The **Humana Healthy Horizons in Kentucky provider website** contains plan information and access to special functionality, like eligibility verification, claim and prior authorization (PA) submission, coordination of benefits (COB) check, and more.
- Address for mailing medical claims
- Pharmacy

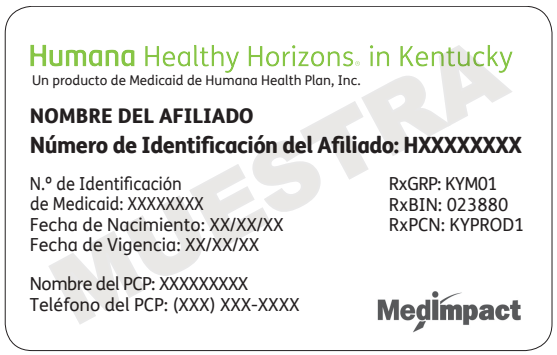
Contact **Member Services** or **Provider Services** if you have questions about pharmacy benefits and services.

Please note: Humana Healthy Horizons may be notified by Kentucky DMS that a member lost eligibility retroactively. When this occurs, Humana Healthy Horizons takes back payments made for dates of service when a member lost eligibility. The take-back code appears on the next explanation of remittance (EOR) for impacted claims.

English ID card:



Spanish ID card:



New member kits

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

The new member 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 Healthy Horizons Provider Directory
- A health assessment survey
- Information about Humana Healthy Horizons' digital tools, designed to improve member engagement

Disenrollment

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

Member disenrollment can be initiated for these reasons:

- Unauthorized use of a member ID card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the delivery of care to the member or other patients

Please notify **Provider Services** if one or more of the previously listed situations occur. **Please refer to the involuntary dismissal section of this provider manual** for procedures to dismiss noncompliant members from your practice. Humana Healthy Horizons can counsel the member or, in severe cases, initiate a request to Kentucky DMS for disenrollment. It is at Kentucky DMS' discretion as to whether it forwards the request to DCBS for actual disenrollment. On receipt, DCBS reviews each member 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 member be involuntarily dismissed from their practice and assigned a new PCP for the following reasons:

- Incompatibility of the provider/patient relationship
- Member has not used a service within 1 year of enrollment in the PCP's practice and the PCP documented unsuccessful contact attempts by mail and phone on at least 6 separate occasions during the year
- Provider inability to meet the medical needs of the member
- Member is incarcerated

Per Humana policy, a provider must take the following steps to request involuntary dismissal of a Humana member from their practice:

A. Attempt communication either in person, by mail and/or phone with the member, and document attempts in the member's medical record.
    a. Make 3 communication attempts regarding incompatibility of the provider/patient relationship where the member 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
    b. Make 6 communication attempts when the member has not used a service within 1 year of enrollment into the PCP's practice.
    c. Communicate at least once regarding the provider's inability to meet the medical needs of the member.

B. The provider's office notifies the member of dismissal by certified letter, which must include the following details:
    a. The reason for which the disenrollment is requested
    b. The specific dates of the documented unsuccessful education/communications attempts and/or communication that the provider is unable to meet the member's needs
    c. If the provider is a PCP, notification of the member that they must contact **Member Services** to choose another PCP

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

A copy of the letter must be mailed or faxed to **Provider Grievance and Appeals.**

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

When a member misses 3 or more consecutive appointments, providers may request assistance from the Humana Care Management department by sending an email to **Care/Case Management**.

Providers do not have the right to request a member's disenrollment from their practice for the following reasons:

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

Transfer requests are not permitted based on race, color, national origin, disability, age or gender.

Referrals for release due to ethical reasons

Humana Healthy Horizons-contracted 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 patient 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 member, the provider's office must notify the member 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 **Member Services** for assistance in finding a preferred in-network provider

A copy of the letter must be mailed or faxed to **Provider Grievance and Appeals**.

Please call **Provider Services** if you have questions about disenrollment reasons or procedures.

Verify eligibility

Members 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 a member of the Humana Healthy Horizons plan, please ask to see photo identification.

Before providing all services (except emergency services), providers are expected to verify member eligibility via **KYHealthNet**.

KYHealthNet is the commonwealth's web portal that offers real-time member eligibility access and MCO enrollment information. It

contains many tools necessary to perform member administrative tasks. To find out more about **KYHealthNet** and to create an account, please visit **KYHealthNet**.

KYHealthNet displays the member'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 Healthy Horizons member eligibility up to 24 months after the date of service. You can search by date of service, date of birth and Medicaid (MMIS) number, or date of birth and Humana Healthy Horizons member ID number. You can submit multiple member ID numbers in a single request.

Please note: While **Availity Essentials** offers historical eligibility information, Humana Healthy Horizons recommends using **KYHealthNet** when verifying eligibility on the date of service.

Each month, PCPs can view a list of eligible members who selected or were assigned to them on the first day of that month. Sign in to Service Fund via **Availity Essentials** to view or print your member list. Eligibility changes can occur throughout the month, and the member list does not prove eligibility for benefits or guarantee coverage. Please use one of the previously described methods to verify member 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 a member missing an appointment or canceling with little notice is a loss of revenue for your organization and prevents others 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 no-show or canceled appointment cases through outreach and, if appropriate, care management. In the system panel, providers can enter information when a Medicaid-covered patient misses or cancels a scheduled appointment. A user guide and video answering questions about entering information is posted for providers on the **Kentucky DMS website** (registration required).

Copayment

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

Member support services and benefits

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

Member services

Humana can assist members 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 via **Member Services** except on the following observed holidays:

- New Year's Day (January 1)
- Martin Luther King Jr. Day (third Monday in January)

- Memorial Day (last Monday in May)
- Juneteenth (June 19)
- Independence Day (July 4)
- Labor Day (first Monday in September)
- Thanksgiving Day (fourth Thursday in November)
- Day after Thanksgiving (Friday after Thanksgiving Day)
- Christmas Day (December 25)

If the holiday falls on a Saturday, we are closed on the Friday before. If the holiday falls on a Sunday, we are closed the Monday after.

Chapter 3: Member rights and responsibilities

Member rights and responsibilities

As a Humana Healthy Horizons contracted provider, you are required to respect the rights of our members. Humana Healthy Horizons members are informed of their rights and responsibilities via their member handbook. You can find a list of our members' rights and responsibilities below.

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

- To prepare advance medical directives pursuant to KRS § 311.621 and KRS § 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 who delivers their care whenever possible and appropriate
- To choose a PCP and change to another PCP in Humana Healthy Horizons' network
    - We send the member a 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 member 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 member, we must set up a visit with a nonnetwork 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 member has legally approved to have the information, or it may be given to someone the member said should be reached in an emergency when it is not in the best interest of the member's health to give it to the member.
- To ask questions and receive complete information about the member'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 member's condition, regardless of cost or benefit coverage
- To take an active part in decisions about the member's healthcare unless it is not in their best interest
- To agree to or decline treatment or therapy
    - If the member declines, the provider or Humana Healthy Horizons must explain what could happen.
    - The provider adds a note about the discussion in the member's medical record.
- To be treated with respect, dignity, privacy, confidentiality, accessibility and to be free from discrimination
- To access 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 member 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 C.F.R. 438.10**
- To be furnished healthcare services in accordance with **42 C.F.R. 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 member's medical records in accordance with applicable federal and state laws
- To be sure that the member's medical records are kept private
- To ask for and receive 1 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 members at cost.
    - Records will be retained for 5 years or longer as required by federal law.
- To agree to or decline having information about the member given out unless Humana Healthy Horizons must provide it by law
- To receive all written member information:
    - At no cost to the member
    - In the prevalent non-English languages of members in our service area
    - In other ways to help members who have trouble reading the information for any reason
- To receive help from Humana Healthy Horizons and providers if the member does not speak English or needs help to understand information
    - Members can receive help free of charge.
- To receive help with sign language if the member is deaf or hard of hearing
- 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 member is female, to be able to go to a woman's health provider in our network for covered woman's health services
- To voice or file an appeal or grievance (complaint) or request a state fair hearing
    - Members also can get help with filing an appeal or a grievance.
    - Members can ask for a **state fair hearing** from Humana Healthy Horizons and/or **Kentucky DMS**.
- To contact the **Office for Civil Rights** 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

- To receive information about Humana Healthy Horizons, its services, its providers, and member rights and responsibilities
- To make advance directives, such as a living will. **Please refer to the advance medical directives section of this manual.**
- To make recommendations to the Humana Healthy Horizons Member 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 a member is approved to go out of network, this is their right as a member.
    - There is no cost to the member.
- To be free to conduct their member rights and know that Humana Healthy Horizons or its providers cannot hold this against them.

Humana Healthy Horizons may not discriminate based on 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 members 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 setting and reaching goals that you and your healthcare provider agree to achieve.
- 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 must cancel, call 24 hours in advance.
- Follow the advice and instructions from your healthcare providers for care to which you agreed.
- Always carry your member ID card. Show it when receiving services.
- Never let anyone else use your member 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. **DCBS county office locations** are available online. You can also contact the **CHFS general information and ombudsman**.
- 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 needed for your care to Humana Healthy Horizons and your healthcare providers.

Chapter 4: Provider and subcontractor rights and responsibilities

Provider responsibilities

Participating providers are expected to treat members with respect. Humana Healthy Horizons members should not be treated differently than patients with other healthcare insurance. **Please refer to the member rights and responsibilities section of this provider manual for more information.**

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 member eligibility and ask for their healthcare insurance information before rendering services, except in an emergency. You can verify member 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 a completed designated form as documentation when submitting early elective delivery claims. The completed forms should be included in the member's chart in the event of audit and, on request, a copy should be submitted to **Kentucky DMS**. These **CHFS forms** are available online.

Americans with Disabilities Act

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 (ICPs) that consider members' special and unique needs. Members in need of interpretation services can call the number on the back of their member ID cards or visit **Humana Healthy Horizons' accessibility resources website** to schedule interpretation services at least 48 hours prior to an appointment. Healthcare providers with patients who require interpretive services may contact **Communication assistance, interpreters, and alternative formats** with date, time, provider phone number and location for an appointment. Please do not include patient health information when emailing. While last-minute interpreters may be available, this cannot be guaranteed, and thus scheduling interpretation services is preferred. Oral interpretation services are provided free to members when communicating 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 a member intentionally permitting others to use their member ID card to obtain services or supplies from the plan or any network provider
- Is suspicious that someone is using another member's ID card
- Has evidence that a member knowingly provided fraudulent information on their enrollment form that materially

affects the member's eligibility

Providers may provide the preceding information via an anonymous phone call to Humana Healthy Horizons' **Special Investigations Unit**. All information is kept confidential.

Entities are protected from retaliation, as provisioned under 31 United States Code (U.S.C.) 3730 (h), for False Claims Act complaints. Humana Healthy Horizons has a zero-tolerance policy for retaliation or retribution against all persons who report suspected misconduct.

Reporting fraud, waste and abuse

Providers can report Medicaid fraud, waste and abuse through the following contacts in this manual's phone book:

- **Provider Services**
- **Kentucky CHFS reporting**
- **Special Investigations Unit direct line**
- **Special Investigations Unit hotline**
- **Ethics Helpline**

Member 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 **HIPAA information online**. The notice informs members about how Kentucky DMS is legally required to protect the privacy of member 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.

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 manage 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 while conducting normal business. As a provider, you should take 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.

Member consent to share health information

Consent is the member's written permission to share their information. Not all disclosures require the member'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).
- Confidentiality of substance use disorder patient records, **42 C.F.R. Part 2**, pertains to federal requirements that apply to all states. While all member data is protected under the HIPAA Privacy Rule, 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 member information on **Availity Essentials** and any health information exchanges. Please explain to your patients that if they do not consent to let Humana Healthy Horizons share this information, providers involved in their care may not effectively coordinate their care. When a member does not consent to share this information, a message displays on the provider portal to indicate that all of the member's health information may not be available to all providers.

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 electronic health record (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 collaborates with providers and hospitals. 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** to learn how to make the KHIE connection.

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 members 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 CHFS, and/or our compliance program:

- General compliance
- Combating fraud, waste and abuse
- **Provider orientation training**
- **Cultural humility, health equity and implicit bias**
- **Health, safety and welfare (abuse, neglect and exploitation) of members**

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. Humana Healthy Horizons may require an attestation of completion for certain training or education. This attestation can include assurance that those your organization designates to support Humana Healthy Horizons receive sufficient information to meet expectations.

The training on the preceding topics is designed to ensure the following:

- Sufficient knowledge of how to effectively perform the contracted function(s) to support members
- 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 and attestations for these topics are available online. Information about **additional provider training** also is 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 **Provider Contracting**. This helps Humana Healthy Horizons keep our records current and is critical to processing your claims. It also ensures our provider directories are up to date and reduces unnecessary calls to your practice. This information is also reportable to the Centers for Medicare & Medicaid Services (CMS).

The following timelines apply for **provider status change** notifications:

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 members	60 calendar days
Healthcare provider's intent to terminate	90 days or as specified in provider agreement

PCPs

All Humana Healthy Horizons members choose or are assigned to a PCP on enrollment in the plan. PCPs help facilitate a medical home for members. This means PCPs help coordinate healthcare for the member and provide additional health options to the member for self-care or care from community partners. PCPs also are required to know how to screen and refer members for behavioral health conditions. **Please refer to the behavioral health and substance use services section of this provider manual for more information.**

Members select a PCP from our provider directory. Members have the option to change to another participating PCP as often as needed. Members initiate the change by calling **Member Services**. PCP changes are effective on the first day of the month following the requested change. When a member changes 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 members sign a medical records release 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 are subject to the following roles and responsibilities as Humana Healthy Horizons providers:

- Supervise, coordinate and provide initial and primary care to members
- 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 members by providing:

- Availability of a personal healthcare provider to assist with coordinating a member's overall care, as appropriate for the member
- Continuity of the member'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 members with the same dignity and respect afforded to all patients—including standards of care and hours of operation
    - Maintaining continuity of the member's healthcare
    - Identifying the member's health needs and taking appropriate action
    - Providing phone coverage for handling patient calls 24 hours a day, 7 days a week
    - **Refer to the PCP after-hours availability section of this provider manual 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)

PCP responsibilities include:

- Following all referral and PA policies and procedures as outlined in this manual
- Complying with the quality assurance, quality investigation and peer review process, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by Humana Healthy Horizons and the commonwealth of Kentucky as outlined in this manual
- Discussing advance medical directives with all members as appropriate
- Providing 30 days of 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, 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 member use
    - Providers are strongly encouraged to provide their race and ethnicity for Humana Healthy Horizons to reference when a member requests a provider with the same race, ethnicity and language as themselves.
- Referring members to behavioral health providers and arranging appointments, when clinically appropriate
- Serving as the ongoing source of primary and preventive care, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, for members younger than 21
- Recommending referrals to specialists
- Participating in the development of care management and treatment plans, and notifying Humana Healthy Horizons of members who may benefit from care management
- Maintaining formalized relationships with other PCPs to refer their Humana Healthy Horizons-covered patients 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 members 18 or older who are of sound mind at the first medical appointment. The discussion should be charted in the member's permanent medical record. A copy of the advance directive should be included in the member's medical record inclusive of other mental health directives.

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

Key contract provisions

We outline 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 members. We appreciate your cooperation in conducting our contractual arrangements and meeting the needs of our members. 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:
        - Send the required 60-day notice if you plan to close your practice to new patients
        - If we are not notified within this time, you will be required to accept Humana Healthy Horizons members 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% 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
    - **Please refer to the grievance and appeals section of this manual for more details about the appeal process.**
- Offering a 24-hour nurse triage phone service for members to reach a medical professional at any time with questions or concerns
- Coordinating benefits for members with primary insurance up to our allowable rate for covered services
    - If the member'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 member'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 if they are not spelled out in our provider agreement.

Chapter 5: Cultural humility, health equity and implicit bias

Participating providers are expected to provide services in a culturally appropriate 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 that race, ethnicity, socioeconomic status, cognitive and physical ability, gender, sexual orientation and gender identity, religion, culture, and primary language 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[1] 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 disparity reports from the Agency for Healthcare Research and Quality (AHRQ) confirm these and other 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, ethnic and other gaps in healthcare with an awareness of cultural needs and an effort to improve communication with a growing number of diverse patients.

Humana Healthy Horizons offers a number of initiatives to deliver services to all members regardless of race, ethnicity, socioeconomic status, cognitive and physical ability, gender, sexual orientation and gender identity, religion, culture, or primary language. These include language assistance services, race, ethnicity and other demographic data collection and analysis, internal staff training, and resources available in Spanish. Other initiatives give providers resources and materials, including tools from health-related organizations, that support awareness of gaps in care and information on culturally appropriate care.

A copy of the Humana Healthy Horizons cultural competency plan is provided at no charge to the provider. Humana Healthy Horizons' **Non-Discrimination, Cultural Competency, Language Proficiency and ADA plan** is available online or on request through **Provider Services**.

[1] Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Institute of Medicine of the National Academies. **https://nap.nationalacademies.org/read/12875/chapter/1**

Chapter 6: Covered services

General services

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

- 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
- 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 (noninstitutional only)
- Independent laboratory services
- Inpatient hospital services
- Inpatient mental health services
- Meals and lodging for appropriate escorts of members
- Medical detoxification, meaning management of symptoms during the acute withdrawal phase from a substance to which the member 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)
- Medical supplies, equipment and appliances (MSEA), including prosthetics, orthotic devices and disposable medical supplies
- 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 members with complex chronic illnesses (includes adult- and child-targeted case management)
- Specialized children 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 nonemergency medical transportation (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 disorder (SUD) services are covered services for Humana Healthy Horizons members. We recognize that behavioral health and physical health function as a part of the whole person, and one can affect the other.

We use a holistic approach to addressing behavioral health and substance use. Humana Healthy Horizons covers a comprehensive range of **behavioral health services**, including:

- Outpatient coverage for:
    - medication management
    - therapy services, including individual, group and family therapy
    - case management offered through key providers
- A broad range of services for both behavioral health and SUDs, including:
    - intensive outpatient
    - partial hospitalization
    - crisis stabilization
    - inpatient or residential treatment based on medical necessity
- Access to community-based resources

Providers, members or other responsible parties can call **Behavioral Health Services** 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 members through efforts aimed at increased well-being, using member-centered, evidence-based practices. Our goal is to provide the level of care needed by the member in the least restrictive setting—the right care, at the right time, in the right setting.

Screening and evaluation

Humana Healthy Horizons requires PCPs to 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 members 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 member'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 resource website**. The site also includes details regarding our referral process and on clinical coordination requirements for such services, including sharing clinical and pharmaceutical information with appropriate consents. Humana Healthy Horizons also provides training for providers specific to care coordination, quality of care and new models of behavioral health interventions.

Continuation of treatment

For members receiving inpatient behavioral health services, Humana Healthy Horizons requires providers to schedule an outpatient follow-up appointment prior to the member's discharge from the facility within 7 calendar 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 members with a severe mental illness

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 members diagnosed with a severe mental illness (SMI). This requirement also applies to members who are discharged from a state-operated or state-contracted psychiatric facility or state-operated nursing facility. The case manager and other identified behavioral health service providers must participate in discharge planning meetings to ensure compliance with the federal Olmstead decision and other applicable laws.

For members 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 member's person-centered recovery plan and level-of-care determination as a part of discharge planning and ensuring continuity of care.

Nurse Advice Line

Members can call the **Nurse Advice Line** 24 hours a day, 7 days a week. This toll-free number is listed on the member's member ID card. Members have unlimited access to an experienced staff of registered nurses to talk about symptoms or health questions.

Nurses assess a member's symptoms, offering evidence-based triage protocols and decision support using the Schmitt-Thompson Clinical Content triage system, the gold standard[2] in telephone triage.

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

Key features of this service include:

- Assessing member symptoms
- Advising members about the appropriate level of care
- Answering health-related questions and concerns
- Providing information about other services
- Encouraging the PCP-member relationship

Emergency behavioral health services

For mental or behavioral health services, members should call a contracted behavioral healthcare provider in their area. The

[2] Schmitt-Thompson Clinical Content. (2024). Gold-standard nurse telehealth triage guidelines. **https://www.stcc-triage.com/**

behavioral healthcare provider can give the member a list of common complications due to behavioral health symptoms and talk to the member about how to recognize them. Members also can call Humana Healthy Horizons' **Behavioral Health Services** toll-free number.

Behavioral health crisis hotline

For emergency behavioral healthcare within or outside the service area, please instruct members 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 Healthy Horizons' **behavioral health crisis line** is staffed by trained personnel and available toll-free throughout the commonwealth of Kentucky. Crisis hotline staff includes or has access to qualified behavioral health service professionals to assess, triage and address specific behavioral health emergencies.

Emergency mental or behavioral health conditions include:

- Behaviors that are a danger to the member or others
- Inability to conduct actions of daily life due to functional harm
- Behaviors that cause serious harm to the body that may cause death

Transportation

Kentucky DMS contracts with the Kentucky Transportation Cabinet, Office of Transportation Delivery to provide **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.

Members can call **NEMT** for help finding the closest transportation service available. Members must call 72 hours before the time the ride is needed.

A list of **transportation brokers and their contact information** is available online or by calling **Kentucky CHFS customer service**.

Humana Healthy Horizons is responsible for covering emergency ambulance and nonemergency ambulance stretcher services. Please call **Provider Services** if you need assistance with emergency or nonemergency ambulance stretcher services.

Go365 for Humana Healthy Horizons

Go365 for Humana Healthy Horizons® is a wellness program that offers members the opportunity to earn rewards for taking healthy actions. Most of the rewards are earned when Humana Healthy Horizons receives the provider's claim for services rendered. Humana Healthy Horizons recommends all providers submit their claims on behalf of a member by March 15, 2026, allowing members time to redeem their rewards.

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

Humana Healthy Horizons members must download the Go365 for Humana Healthy Horizons mobile app and register for access to begin earning rewards. As members complete key healthy actions, rewards accumulate on their Go365 account. Those rewards can be redeemed in the Go365 mall for electronic gift cards to popular retailers. Rewards are nontransferable and have no cash value. Electronic gift cards may not be used for tobacco, alcohol, firearms, lottery tickets and other items that do not support a healthy lifestyle.

Members can qualify to earn rewards by completing 1 or more of the following healthy activities:

Activity	Reward criteria	Reward amount
Annual wellness visit	Complete an annual wellness visit with a PCP. Available to members 3 years and older.	$15 in rewards per year
Breast cancer screening	Get a mammogram. Available to female members 40 and older.	$25 in rewards per year
Cervical cancer screening	Get a cervical cancer screening as part of a routine pap smear. Available to female members 21 and older.	$15 in rewards per year
Chlamydia screening	Get a chlamydia screening when sexually active or as recommended by your healthcare provider. Available to all female members.	$15 in rewards per year
Colorectal cancer screening	Get a colorectal cancer screening as recommended by your PCP. Available to members 45 and older.	$15 in rewards per year
Comprehensive diabetic screening	Get an annual HbA1c and blood pressure screening with your PCP. Available to diabetic members 18 and older.	$25 in rewards per year
Diabetic retinal eye exam	Get a retinal eye exam. Available to diabetic members 18 and older.	$25 in rewards per year
Digital onboarding	Download the Go365 for Humana Healthy Horizons app and complete registration. Available to all members.	$10 in rewards per lifetime
Flu shot	Get the flu vaccine. If given by someone other than a PCP or at a pharmacy, upload a photo for documentation in the Go365 app. Available to all members.	$20 in rewards per year
Haircuts for Kids	Redeem this reward through the Go365 app between March – April or July – September. Redeem by uploading a photo of your child's school registration form, school ID or class schedule in the Go365 app. Available to members in grades K–12, ages 5–20.	$20 in rewards per haircut, max $40 per year
Health Risk Assessment (HRA) – new members	New members can complete an HRA within 30 days of enrollment in Humana Healthy Horizons. The HRA can be done in 1 of 4 ways: • Complete the HRA through the Go365 for Humana Healthy Horizons app. • Fill out and send back the HRA in the envelope from your welcome kit. • Call 866-331-1577 (TTY: 711), Monday – Friday, 8 a.m. – 5:30 p.m., Eastern time. • Create a MyHumana account and complete and submit the HRA online (available via desktop only). Available to all members.	$20 in rewards per lifetime

Activity	Reward criteria	Reward amount
HRA – annual members	Annual members can earn $20 for completing the HRA between January 1 and March 31.	$20 in rewards per year
Human Papillomavirus Vaccine (HPV)	Must complete both doses to receive reward. Available to members 9–13.	$80 in rewards per lifetime
Level-of-care video	Watch a video in the Go365 app that explains when to access the emergency room. Available to members 19 and older.	$5 in rewards per year
Postpartum visit	Complete 1 postpartum visit within 7 to 84 days after delivery. Available to all female members.	$25 in rewards per pregnancy
Prenatal visit	Complete 1 prenatal visit. Available to all pregnant female members.	$5 in rewards per visit, up to 10 visits, max $50 per pregnancy
Tobacco cessation coaching	Work with a coach over the phone to quit smoking or vaping. • $25 for completing 2 calls within 45 days of enrolling in coaching. • $25 for completing 6 more calls (8 total) within 12 months of enrolling in coaching. • Enroll by calling 877-264-2550 (TTY: 711). When prompted, select option 1. Available to members 12 and older.	Up to $50 in rewards per lifetime
Weight management coaching	Work with a coach over the phone to reach or keep a healthy weight. • $15 for enrolling and submitting a PCP form for well-being checkup. • $15 for completing coaching, 6 calls total, within 12 months of enrolling. To enroll, call 877-264-2550 (TTY: 711). When prompted, select option 2. Available to members 12 and older.	Up to $30 in rewards per year
Well-baby visit	Complete a wellness visit with a pediatrician. Available to members from birth to 15 months.	$10 in rewards per visit up to 6 visits, max $60 per year
Well-child visit	Complete a wellness visit with a pediatrician. Available to members 16–30 months.	$10 in rewards per visit up to 2 visits, max $20 per year

Urine drug testing policy

Humana Healthy Horizons implemented the Kentucky DMS urine drug testing (UDT) policy, effective July 1, 2020. We now process these claims for payment as indicated by the Kentucky DMS policy, per the provider's contract agreement and/or the Humana Healthy Horizons out-of-network payment policy. Once the member exceeds the benefit limit as established by 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 member's 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 provider grievance and appeals section of this manual. The **KDMS UDT policy** can be viewed online for more details.

For additional questions regarding this policy, please contact your **provider relations representative**.

Telehealth services

Virtual urgent care services—MDLIVE (telehealth)

Humana Healthy Horizons members 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, 7 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 emergency rooms (ERs) and urgent care facilities. All prescriptions can be sent directly to a local pharmacy if medically necessary.

MDLIVE's scope of services includes:

- Urgent care services for nonemergency needs, 24 hours a day, 7 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

Available board-certified provider types include internal medicine and family practice.

Early and Periodic Screening, Diagnostic and Treatment

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federally mandated program developed for Medicaid recipients from birth through the end of their 21st birth month. All Humana Healthy Horizons members 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 members.

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 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 integrated into well-child visits at 1, 2, 5 and 6 months

Special services

Under the EPSDT benefit, Medicaid provides comprehensive coverage for all services described in § 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 Kentucky Medicaid covers those services. 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 and behavioral.

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 online via the **American Academy of Pediatrics website**.

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 member's 21st birth month)	

Child blood lead screenings

The Kentucky 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: 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 are screened 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 1 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 are 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 for Public Health and the Kentucky DMS **Vaccines for Children (VFC) program** offers certain vaccines free of charge to Medicaid members younger than 21.

When administering VFC vaccines, providers should never bill 2 different payers (e.g., 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 3 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** after 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 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 members.

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 members.

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 for research purposes or experimental in nature
- Gender-affirming surgical services
- Sterilization of a mentally incompetent or institutionalized member
- Services provided in countries other than the United States, unless approved by the secretary of 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 member 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 members 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 member is not greater than it would be if the service were provided in network. **For more information, please refer to the copayment section of this manual.**

Value-added services

Humana Healthy Horizons offers members extra benefits, tools and services (at no cost to the member) 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 more than the amount, duration and scope of covered services listed in this manual.

In instances when 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 members have specific enhanced benefits:

Value-added service	Details and limitations
Baby and Me meals	Up to 2 precooked, home-delivered meals per day are provided for 10 weeks for pregnant women who are high risk. Care manager approval required.
Convertible car seat or portable crib	Pregnant members who enroll and actively participate in our HumanaBeginnings® care management program and complete a comprehensive assessment and at least 1 follow-up call with a HumanaBeginnings care manager can select 1 convertible car seat or portable crib per infant, per pregnancy.
Criminal expungement services	For members 18 and older, financial assistance of up to $340 for criminal record expungement, as allowed per the Kentucky Court of Justice, per lifetime, is provided. Funds are not paid directly to the member.
Disaster preparedness meals	1 box of 14 shelf-stable meals before or after a natural disaster is provided twice per year. The member must not live in a residential or nursing facility. The governor must make a disaster declaration for the member to be eligible for the meals.
Doula services*	Doula assistance is provided for pregnant members to provide emotional and physical support to the laboring mother and her family. 5 prenatal visits, 3 postpartum visits and 1 visit for delivery assistance per pregnancy are provided.
General Education	For members 18 and older, GED test preparation assistance, including a bilingual advisor, access to

Value-added service	Details and limitations
Development (GED®) testing	guidance and study materials, and unlimited use of practice tests are provided. Test preparation assistance is provided virtually to allow maximum flexibility for members. This benefit also includes test-pass guarantee to provide members multiple attempts at passing the test.
Haircuts for Kids	Members can earn $20 in rewards, twice per year for getting a haircut. Members redeem this reward through the Go365 for Humana Healthy Horizons app between March and April or July and September. To redeem, members upload a photo of their child's school registration form, school ID or class schedule to the Go365 app. This service is available to members in grades K–12, ages 5–20. $20 in rewards per haircut, max $40 per year
Housing assistance	For members 18 and older, up to $500 per member per year (unused allowance does not roll over to the next year) is provided to assist with the following housing expenses: • Apartment rent or mortgage payment (late payment notice required) • Utility payment for electric, water or gas (late payment notice required) • Trailer park and lot rent if this is the member's permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority Plan approval is required. • The member must not live in a residential facility or nursing facility. • Funds are not paid directly to the member. If the bill is in the spouse's name, a marriage certificate may be submitted as proof.
Postdischarge meals	14 refrigerated home-delivered meals following discharge from an inpatient or residential facility are provided. This benefit is limited to 4 discharges per year.
Self-monitoring devices—blood pressure monitoring kit	Members 21 and older under care management may receive 1 digital blood pressure kit once every 3 years. The kit includes the cuff and monitor. Care manager approval is required.
Self-monitoring devices—weight scale	Members 21 and older under care management may receive 1 weight scale every 3 years. Care manager approval is required.
Smartphone app for diabetes management	For members 18 and older with type 2 diabetes who are not already receiving care management services, unlimited access to an innovative digital therapeutic smartphone app for diabetes management is provided.
Smartphone services	Smartphones provide easy access to health-related information and enable members to stay connected to their care team and health plan. Humana Healthy Horizons members who qualify for the federal Lifeline program are eligible to receive a free smartphone with monthly talk minutes, text and data.
Sports physical*	1 sports physical per year is provided for members 6 to 18.
Tobacco and vaping cessation coaching	Tobacco and vaping cessation coaching helps members 12 and older to stop nicotine product usage. The program is designed as a monthly engagement for a total of 8 coaching calls, but the member has 12 months to complete the program if needed. The program also offers support for both over-the-counter (OTC) and prescription nicotine replacement therapy for members 18 and older.
Weight management coaching	Weight management coaching helps members 12 and older achieve or maintain a healthy weight. After receiving provider clearance, the member can complete 6 sessions with a wellness coach (approximately 1 session over a phone call per month for a period of 6 months).

Value-added service	Details and limitations
Workforce development program	For members 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); engaging in and maintaining meaningful work (e.g., job support and retention coaching); and 3 round-trip bus vouchers for transportation while enrolled in the program, where available. Member reimbursement is provided for childcare of $40 maximum per quarter, up to 4 times per year, for caretakers seeking job opportunities. The member must participate in the Humana Workforce Development program to be eligible for reimbursement consideration.

* Humana Healthy Horizons publishes **billing guidelines online for these services**.

Direct access

Humana Healthy Horizons makes covered services available and accessible to members 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 a member 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 are completed.

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

- Primary care vision services, including the fitting of eyeglasses, 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 members younger than 18
- Immunizations to members 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
- Specialist services appropriate for the member's condition and identified needs (for members with special healthcare needs determined through an assessment in need of a course of treatment or regular care monitoring)
- Women's health specialists

Chapter 7: 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 review a previous decision made by Humana Healthy Horizons to deny, suspend or terminate services.

For purposes of this section, coverage denial is Humana Healthy Horizons' determination that a treatment or service is specifically limited or excluded under the member'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 a member if you have the member's written consent. For details about filing on behalf of a member, **please refer to the member grievance and appeals section in this provider manual**. Humana Healthy Horizons ensures that no punitive or retaliatory action is taken against a member or provider who files a grievance or appeal or a provider who supports a member'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 EOR. 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.

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 and verbal submission

If you have an inquiry, grievance or appeal, please contact **Provider Services**. Based on the type of issue, a Humana Healthy Horizons associate with the designated authority reviews your issue or complaint. To ensure proper handling, please indicate whether you are filing an inquiry, grievance or appeal.

To file a written appeal, mail your appeal request to **Provider Grievance and Appeals.**

Digital submission

Providers can submit encrypted grievances regarding claim issues or appeals online via **Availity Essentials**. To ensure proper handling, please indicate in the comment box whether you are filing an inquiry, grievance or appeal.

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 only on behalf of the member for an adverse benefit determination and receive a decision no later than 72 hours after receipt of the request. **Please refer to the member grievance and appeals section in this provider manual for more information**. An expedited appeal is deemed necessary when a covered person is hospitalized or if the standard appeal time frame would result in:

- Placing the health of the member (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 (EIR). The provider must submit a request for an EIR within 60 calendar days of receiving final decision on the internal appeal. Humana Healthy Horizons partnered with Kentucky DMS to create an EIR Intake Form. Providers are required to use this form and submit to Humana Healthy Horizons to request an EIR.

The **EIR Request Form** is available online.

Using the form:

- Use this form for all EIR requests. Verbal EIR requests are not considered.
- Written requests not on this form are not considered.

Use this form after you exhaust Humana Healthy Horizons' internal appeal process.

An EIR must be submitted within 60 calendar days of the MCO's final adverse determination. The 60-calendar-day timeline begins with one of the following:

- Date that the notice was received electronically
- Date that the notice was received via fax, per the date and time documented on the fax transmission
- Postmark date on the envelope containing the notice
    - If sent by mail, an additional 3 days are added.

Do not use the claim Explanation of Benefits (EOB) date to calculate timely filing.

Any category on the form that is marked with an asterisk must be complete for the form to be considered.

Be as specific as possible when stating your area of dispute or why you believe the MCO's decision on appeal is erroneous. If you attach a document, provide a specific explanation of its contents.

Do not submit duplicate requests for EIR.

Types of cases eligible for EIR:

- Service coverage requirements which include a claim involving:
    - Whether the given service is covered by the Medicaid program; or
    - Whether the provider followed the MCO requirements for the covered service
- Claim payment determination: cases stemming from the dollar amount paid on a claim or denial of a claim
- Medical necessity adverse benefit determination: cases stemming from an adverse medical necessity determination

Types of cases not eligible for EIR:

- Cases in which the form is not filled out in its entirety
    - Please note: incomplete forms may be resubmitted within the timely filing period.
- Cases in which MCO internal appeal rights have not been exhausted

- Cases in which the timely filing period has passed
- Claims that are part of an investigation by our Special Investigations Unit (e.g., fraud, waste or abuse investigation)
- Medicare claims or denials
- Disputes based on reimbursement provisions or other provisions addressed in the proprietary agreement between the provider and the MCO

The request must contain the following:

- Clear identification of each specific issue and dispute related to the adverse final decision issued by the external independent third-party reviewer
- Clear statements of the basis on which the external independent third-party reviewer's decision on each issue is believed to be erroneous
- The name, mailing address, phone number, fax number and email address for correspondence related to the external independent third-party review

Disputes should be limited to documentation you submitted for Humana Healthy Horizons' internal appeal process and any other information contained in our final decision.

An external independent review is not granted for a claim in which the member already requested an administrative hearing. If a member files a request for an administrative hearing regarding a claim about which a provider has already filed a request for an external independent third-party review, then the review is not processed until the member's appeal is fully adjudicated.

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 5 business days. The external independent review entity issues a final decision within 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 within 30 calendar days of the external independent review entity's decision.

Kentucky DMS request for review of coverage denials

If you exhaust 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 notifies 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 not to exceed $1,000.

Requests for Administrative Hearings should be sent to:

Cabinet for Health and Family Services
Department for Medicaid Services
Division of Program Quality and Outcomes
275 East Main St., 6C-C
Frankfort, KY 40621-0001

Chapter 8: Member grievance and appeals

Member grievance, appeal and state fair hearing requests

Grievances (complaints)

Members may file a grievance when they are dissatisfied with Humana Healthy Horizons or a provider. Providers may assist members in filing a grievance when the member provides written consent. Grievances can be filed verbally or in writing by:

- Calling **Member Grievance and Appeals**
- Submitting a request online
- Faxing the appeal to **Member Grievance and Appeals**
- Writing a letter that includes the following information:
    - Member name
    - Member ID number from the front of the Humana Healthy Horizons ID card
    - Member address and phone number
    - Explanation of issue

To submit written grievances, mail the letter to **Member Grievance and Appeals.**

Humana Healthy Horizons sends an acknowledgement letter within 5 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:

- A member who files a grievance
- A provider who supports a member's grievance or files a grievance on behalf of a member with written consent

Appeals

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

Appeals can be filed by:

- Calling **Member Services**
- Filling out the form in the back of the member handbook
- Submitting a request online
- Faxing the appeal to **Member Grievance and Appeals**
- Writing a letter that includes the following information:
    - Member name
    - Member ID number from the front of the Humana Healthy Horizons ID card
    - Member address and phone number
    - All information that explains the appeal

Mail the form or letter to **Member Grievance and Appeals.**

Humana Healthy Horizons sends an acknowledgement letter within 5 business days of the day the appeal is received.

After we complete the review of your appeal, we send the member a letter within 30 calendar days to let them know our decision.

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

- The 30-day time frame could seriously jeopardize the member'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 fast as needed based on the member's health. Negative actions are not taken against:

- A member or provider who files an appeal
- A provider who supports a member's appeal or files an appeal on behalf of a member with written consent

If we extend the time frame for the appeal or expedited appeal (we are requesting it, not the member), we make reasonable efforts to give the member prompt oral notice of the delay and give them written notice within 2 calendar days of the reason for the decision to extend the time frame. If we need more information to make either a standard or an expedited decision about the appeal, we:

- Write the member and tell them what information is needed. For expedited appeals, we call the member right away and send a written notice later.
- Explain why the delay is in their best interest.
- Decide no later than 14 days from the day we asked for more information.
- Inform the member of their right to file a grievance if they disagree with this decision.

The member or someone the member chooses to act for them may:

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

State fair hearings

The member also has the right to ask for a state fair hearing from Kentucky DMS if they complete the Humana Healthy Horizons appeal process and disagree with our decision. A state fair hearing is the member's opportunity to give more information and facts and to ask questions about the decision before an administrative law judge. The judge in your state fair hearing is not a part of Humana Healthy Horizons in any way.

The member can request a state fair hearing in writing, by mail or fax, to the **Cabinet for Health and Family Services.**
The member must request a hearing within 120 days of the date on our appeal decision letter.

To qualify for a state fair hearing, the member request should:

- Be received within 120 days from the date on our appeal decision letter

- Explain why they need a state fair hearing
- Tell us the date of the service and the service type that was denied.
    - Please include a copy of the most recent appeal decision letter they got from us.

A state employee, called a hearing officer, oversees the member's state fair hearing. The hearing officer sends the member a letter with the date and time of the hearing. The letter also explains the hearing process. If the member does not want to speak or is unable to speak for themself, they can choose someone to speak for them at the hearing. The member can request a state fair hearing, or they can ask someone to do it for them. The member can choose anyone they want to speak for them, including a friend, their doctor, a legal guardian, a relative or an attorney. If they pick a person to attend the state fair hearing for them, that person is their authorized representative. If the member did not already do so during the appeal, they must fill out an appointment of representative (AOR) form to let someone else speak for them.

If the member filled out an AOR form for the appeal, the appointed representative can speak for the member. If they did not, the member can call us to get one for the state fair hearing.

If the member requests a state fair hearing and wants their Humana Healthy Horizons benefits to continue, they must file a request with us (Humana) within 10 days from the date on our Notice of Plan Appeal Resolution letter.

The state fair hearing decision is made within 90 calendar days from the date Kentucky DMS receives the request.

If the member has an urgent health condition, they can ask for an expedited hearing. If the hearing determines Humana Healthy Horizons made the correct decision, the member may have to pay the cost of the services provided for the benefits that were continued during the state fair hearing.

Continuation of benefits

For some adverse benefit determinations, the member may request to continue services during the appeal and **state fair hearing** process. The member can request that services be continued if:

- they already receive the services that might be reduced, suspended or terminated
- the services were ordered by an authorized provider
- the period covered by the original authorization has not yet ended

If the member requests continuation of services within 10 days of the date on our Notice of Adverse Benefit Determination letter, or on or before the date we informed them the service would be reduced, suspended or terminated (whichever is later), their benefits continue until one of the following occurs:

- the original authorization period for your services ends
- the member withdraws their appeal or fair hearing request
- the member does not request a **state fair hearing** with continuation of benefits within 10 days from the date Humana Healthy Horizons mails the appeal decision letter
- the administrative law judge issues a decision that is not in the member's favor following a state fair hearing

If the appeal was denied and the member requests a **state fair hearing** with continuation of services within 10 days from the date on the Notice of Plan Appeal Resolution letter, their services will continue during the state fair hearing process.

However, if the outcome of the appeal or state fair hearing remains the same as the first decision to deny the member's services, they may be required to pay for these services.

Chapter 9: Credentialing and recredentialing

Provider credentialing and recredentialing

All providers appearing in the Humana Healthy Horizons 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 function as PCPs or those who appear in the provider directory
- Behavioral health practitioners:
    - Psychiatrists and other providers
    - 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 5-year work history
- Current U.S. Drug Enforcement Administration (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 who require special training—successful completion of training program
    - Board certification, as applicable

    - Current malpractice insurance coverage in 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 Enumeration 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 medical or civil disciplinary actions
    - Lack of member grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall member satisfaction
    - Other quality of care measurements/activities

Council for Affordable Quality Healthcare 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 is not, 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 DEA certificate
    - All buprenorphine prescribers must have an "X" DEA number.
- Explanation of all lapses in work history of more than 6 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 Kentucky DMS, CMS and NCQA. Humana Healthy Horizons credentials and recredentials all licensed independent providers, including facilities and

nonproviders, 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 only appears in the provider directory once credentialing is complete.

You can submit a completed CAQH application via **CAQH's provider portal**.

Organizational credentialing and recredentialing

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

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Freestanding ambulatory surgery centers
- Hospice providers
- Behavioral health facilities providing mental health or SUD services in an inpatient, residential or ambulatory setting
- Dialysis centers
- Physical therapy, occupational therapy and speech language pathology (PT/OT/SLP) facilities
- Rehabilitation hospitals (including outpatient locations)
- Diabetes education
- Portable X-ray suppliers
- RHCs and FQHCs
- Freestanding 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 1 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 is informed of the credentialing committee's decision within 60 business days of the committee meeting. Organizational providers are reassessed at least every 3 years.

Provider recredentialing

Network providers, including individual and organizational providers, are recredentialed at least every 3 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 **credentialing and recredentialing** prior to presentation to the credentialing committee. If information obtained during the credentialing or recredentialing process varies 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 a 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 if 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 an NCQA-accredited credential verification organization. They also must successfully pass a predelegation audit demonstrating compliance with NCQA federal and state requirements. A predelegation 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 Kentucky 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 calendar 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. Reconsideration requests can be sent to **reconsideration of credentialing/recredentialing decisions**.

On reconsideration, the credentialing committee may affirm, modify or reverse its initial decision. Humana Healthy Horizons notifies the applicant in writing within 60 calendar 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 **reconsideration of credentialing/recredentialing decisions team** for reconsideration by the credentialing committee.

Chapter 10: Pharmacy

Humana Healthy Horizons' 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, and this website can be accessed through a desktop computer or mobile device. When providers visit the **MedImpact** website, a welcome page for Kentucky DMS hosted by MedImpact displays; providers can then select the provider portal at the top of the page and the Resources tab. The Resources tab has downloadable documents, including:

- 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 member's area that accepts Medicaid. The Contact tab has phone numbers for **MedImpact** if providers have medical and/or pharmacy questions or concerns.

Humana Healthy Horizons recommends that providers take a few minutes to review the **MedImpact** website to familiarize themselves with pharmacy benefit information. For questions about the **MedImpact** website or pharmacy benefit, contact **MedImpact**.

Medications administered in the provider setting

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

- Review Humana Healthy Horizons' **prior authorization and notification lists online** for current PA requirements and changes to the preauthorization list.
- Obtain forms via Humana Healthy Horizons' **prior authorization website.**
- Send a request via the **Medication Intake Team.**
- To view current medical and pharmacy coverage policies, please visit the **Medical and Pharmacy Coverage Policies** webpage.

Pharmacy lock-in program

The **pharmacy 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 member. Humana Healthy Horizons members who meet the program criteria are locked into 1 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 a member's claim activity reveals a health and safety concern due to the number and type of controlled substance prescriptions or misuse of prescriptions, the member is considered a candidate for the lock-in program.

Members identified as candidates for the lock-in program receive written notification from Humana Healthy Horizons, along with the designated lock-in pharmacy's information and details regarding the member's right to appeal the decision.

Members are initially locked-in for a total of 12 months during which the member can only request a change from their designated lock-in pharmacy once. After the 12-month lock-in period expires, the lock is released for 6 months. A utilization review is then completed to determine if the member 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.

Lock-in referrals

Humana Healthy Horizons monitors members' claim history and utilization to identify members who may benefit from inclusion in the pharmacy lock-in program. Members also may be referred for evaluation to participate in the lock-in program by their PCP or a specialist by contacting the **pharmacy lock-in program**. Excluded from enrollment in the lock-in program are members who are:

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

Kentucky Prescription Assistance Program

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

Chapter 11: Utilization management

Utilization Management (UM) helps maintain the quality and appropriateness of healthcare services provided to Humana Healthy Horizons members. 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 members; 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 member'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 can be directed to **Medical Services**.
- Behavioral health inquiries can be directed to **Utilization Management: behavioral services**.

Please keep the following in mind when contacting UM staff:

- Staff are available Monday – Friday, 8 a.m. – 6 p.m., Eastern time.
- Staff can receive inbound communications regarding UM issues after normal business hours.
- Staff identify themselves 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 members 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.

Member health is always Humana Healthy Horizons' top 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 at Medical and Pharmacy Coverage Policies (Humana.com), in the "Humana Physician News" newsletter and on request by email to one of the following UM departments:

- Medical health inquiries can be directed to **Utilization Management: medical services**.
- Behavioral health inquiries can be directed to **Utilization Management: behavioral services**.

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. 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 5 business days of the determination.

Referrals and prior authorization

Referrals

Humana Healthy Horizons members may see any participating provider within our network, including specialists and inpatient hospitals. Members may self-refer to any participating provider. PCPs do not need to arrange or approve these services for members if applicable benefit limits have not been exhausted. Exceptions to this policy apply to members who are designated to participate in the **pharmacy lock-in program**. **Please refer to the pharmacy 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 a member requires medically necessary services from a nonparticipating provider, the provider may need to call to obtain **prior authorization**.

Second opinions for nonparticipating providers

Although Humana Healthy Horizons does not require referrals, a member may receive a second opinion. Providers or members may request a second opinion at equal cost to the member if the service was obtained in network. **Please refer to the copayment section of this manual for more information.**

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 member's PCP or the specialist practice group from which the first opinion was obtained.
- The provider must practice 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 **prior authorization** is requested for a service rendered in the same month, member eligibility is verified at the time the request is received. When the service will be rendered in a subsequent month, authorization is given contingent on member eligibility on the date of service. Providers must verify eligibility on the date the service will be rendered. Humana Healthy Horizons is not able to pay claims for services provided to ineligible members. 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 notifies the member 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 member's health condition requires, but no later than 2 business days following the authorization request date. The time frame for a standard authorization request may be extended up to 14 calendar days if the provider or member 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 member'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 member's life, health, or ability to attain, maintain or regain maximum function, Humana Healthy Horizons completes an expedited authorization decision within 24 hours and provides notice as expeditiously as the member'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 Humana Healthy Horizons' **Kentucky Medicaid prior authorization list online**.

Requesting prior authorization

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

Medical and behavioral health

PA for healthcare services can be obtained by contacting **Utilization Management: medical services,** through **Availity Essentials**, or via **prior authorization forms** posted on our website and submitted to **Utilization Management: medical services**.

When requesting authorization, please provide the following information:

- Member/patient name and Humana Healthy Horizons member 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**, **Avēsis** 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 Healthy Horizons' prior authorization website** or review the **Kentucky provider prior authorization details online**.

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
- Computerized tomography scan
- Magnetic resonance angiography
- Magnetic resonance imaging
- Nuclear medicine
- Positron emission tomography
- Single-photon emission computerized tomography scan
- Physical therapy
- Occupational therapy
- Speech therapy

Submit authorization requests to EviCore healthcare:

- By visiting the **EviCore healthcare website** (registration required)
- By contacting **Evicore healthcare** directly

WholeHealth Living

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

- Use WholeHealth Living's **online portal**
- Contact **WholeHealth Living** directly

Avēsis

For authorization related to dental and vision services, Humana Healthy Horizons partners with **Avēsis**. Dental and vision authorization can be obtained by contacting **Avēsis** directly.

Pharmacy

Please refer to the pharmacy chapter of this manual for details about pharmacy authorization.

Chemotherapy

For adults 18 and older, Humana Healthy Horizons partners with **Evolent Health** for chemotherapy agents and supportive and symptom management drug PA requests.

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 submit a request for PA to **Evolent Health**:

- Use **Evolent Health's website** by logging in with your username and password. Login information can be obtained directly from **Evolent Health**.
- Contact **Evolent Health** directly to reach their intake coordinator department.

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 are determined when the claim is received for processing.

Administrative denials may be rendered when applicable authorization procedures are not followed. Members 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. Submitted claims that do not meet the necessary criteria as described below are administratively denied.

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

See table on the next page

Cause for review	Request time frame requirements
Member was not enrolled with Humana Healthy Horizons on the date of service, but member was retroactively assigned coverage for the date of service through Medicaid enrollment process.	**Within 12 months of** the date eligibility was updated with Kentucky DMS
The service is related to another service that already received prior approval, was already performed and the new service was not needed at the time the original prior authorized service was performed.	**Within 90 calendar days from:** • The date of service, or • The inpatient discharge date, or • The initial date of a service, for a service that spans several months, or • The date of the primary insurance carrier's Explanation of Payment or authorization denial, which demonstrates the service was not a covered service
The need for the new service was determined at the performance of the original prior authorized service.	

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

- Patient name and Humana Healthy Horizons member 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** or by contacting **Availity Essentials** directly.

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

Exceptions to this policy apply to members in the **pharmacy lock-in program**.

More details regarding authorization inquiries for our **Evicore healthcare**, **WholeHealth Living** and **Avēsis** partners are available within other sections of this manual.

Obtaining authorization to a nonparticipating provider

Authorization is required for members 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.

Chapter 12: Quality

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 **Quality Improvement**.

Quality management activities

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

- Member 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 members.
    - 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 is reaudited 6 to 12 months from the initial audit.
    - **Quality Improvement via KYQIMedicaid@humana.com** is engaged to provide education and training when a provider fails a quarterly audit.
- If the provider fails multiple audit 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 member medical records is 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 is monitored until problem resolution occurs. Reevaluations occur to ensure sustained improvement.
    - If 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 opportunities in care for our members. Healthcare Effectiveness Data and Information Set (HEDIS®) measures now include care coordination measures for members transitioning from a hospital or emergency department to home, adding opportunities for hospitals and providers to improve care. In addition to medical record reviews, information for HEDIS is gathered administratively via claims, encounters and submitted supplemental data. There are 2 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) **available online**. 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 1 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 submitted to Humana Healthy Horizons via

either secure email or file transfer protocol transmission. We also accept lab data files via the same methods. Humana Healthy Horizons partners with various EMRs to provide member summaries and detail reports and to automatically retrieve scanned charts.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)—The CAHPS survey includes measures that reflect member satisfaction with the provider's care and service.
    - Each year surveys are sent to our members that ask multiple questions to assess how the provider and Humana Healthy Horizons are performing.
- Occurrences and adverse events reporting—Unexpected occurrences and adverse events involving members 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.
- Member complaints—Member complaints and grievances pertaining to quality of care and concerns may be referred to **Quality Improvement** 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 members or topics mandated by Kentucky DMS.

Quality improvement requirements

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

- PIPs—Ongoing measurements and interventions 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 member health outcomes and member satisfaction.
- Member medical record reviews—Medical record reviews evaluate documentation patterns of providers and adherence to member medical record documentation standards; Medical records also may be requested when investigating complaints of poor quality or service or clinical outcomes. **Please refer to the external quality reviews section of this manual for more information on medical record reviews.**
- Performance measures—Collect data on patient outcomes as defined by HEDIS or otherwise defined by NCQA.
- Surveys—Implement CAHPS, provider satisfaction, behavioral health and special surveys to support quality/ performance improvement initiatives.
- Peer review—Review 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 members 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 members 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 monitors appointment time compliance using secret shopper surveys in accordance with contractual requirements.

Members 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, 7 days a week
Urgent care	Not to exceed 48 hours from date of a member's request
Routine care needs	Not to exceed 30 calendar days from date of a member's request
Non-PCP specialists	
Patients with:	**Should be seen:**
Emergency needs	Immediately on presentation, 24 hours a day, 7 days a week
Urgent care	Not to exceed 48 hours from date of a member's request
Routine care needs	Not to exceed 30 calendar days from date of a member's request
Behavioral health providers	
Patients with:	**Should be seen:**
Care for non-life-threatening emergencies	Crisis stabilization must be provided within 6 hours
Urgent care	Within 48 hours
Initial visit or routine office visit	Must not exceed 10 business days
Postdischarge from an acute psychiatric hospital	Within 7 calendar days

Providers must contact members who missed an appointment within 24 hours to reschedule. Other referrals may not exceed 60 calendar days.

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

A member should be seen as expeditiously as the member's condition warrants based on the severity of symptoms. If a provider is unable to see the member 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, 7 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 service. A Medicaid-eligible PCP must provide coverage.

PCPs must maintain formalized relationships with other PCPs to refer members 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 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 member 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 can 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 members to leave a message.
- The office phone is answered after hours by a recording that directs members to go to the emergency room for any services needed.
- After-hours calls are returned more than 30 minutes from the initial call.

Preventive guidelines and clinical practice guidelines

These clinical treatment protocols are systematically developed statements that help providers and members 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 on outcomes of care. Humana Healthy Horizons monitors provider implementation of guidelines by analyzing claim, pharmacy and utilization data.

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

- **Humana Healthy Horizons in Kentucky provider website**
- Provider manual updates
- Humana Physician News (newsletter)

Preventive health and clinical practice guidelines can be obtained from your **provider relations representative.**

Quality Assurance and Performance Improvement program

Humana Healthy Horizons has a Quality Assurance and Performance Improvement (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, member 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 **Quality**

Improvement.

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 members.

Provider maintenance of medical records

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

- Humana Healthy Horizons requires that each member or their representative is entitled to 1 free copy of their medical record.
    - Additional copies are made available to members at cost.
- Medical records should be preserved and maintained by the provider for a minimum of 5 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 member medical records as part of provider monitoring as described in the medical record reviews section of this manual. 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 member 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 member medical records

The following standards apply for member medical records:

- Member/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 members at the first medical appointment and chart that discussion in the member'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 is evaluated by another reviewer.

A member'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
- Current diagnosis being addressed through treatment (if behavioral health in nature, must be aligned with the current edition of the DSM)
- 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

A member's medical record must include, at a minimum, the following for hospital and mental hospital visits:

- Member'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 nonmental hospitals only, the date of operating room reservation and the justification of emergency admission, if applicable

Medical record reviews

Humana Healthy Horizons performs quarterly audits of randomly selected member medical records. Periodically you may receive requests for copies of member medical records. Your contract with Humana Healthy Horizons requires that you furnish member medical records to us for this purpose. Member medical record reviews are a permitted disclosure of a member's PHI in accordance with HIPAA. The record reviewers protect member 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 members.

Humana Healthy Horizons monitors a provider's actions to ensure they comply with Kentucky DMS and Humana Healthy Horizons policies, including:

- Maintaining the continuity of the member's healthcare
- Maintaining a current medical record for the member, including documentation of all PCP and specialty care services
- Documenting 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 providers' member medical records to ensure compliance with the medical records standards outlined in the contract and described above.

After completing member medical record reviews, Humana Healthy Horizons and **Quality Improvement** 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 preventive 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 in

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 collaborate with affected providers to develop an action plan to help those providers improve their practice. If a provider continues to underperform, 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.

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 updated annually. More information about performance measurement is **available online.**

Chapter 13: Claims and encounters

Claims

Humana Healthy Horizons follows the claims reimbursement policies and procedures set forth by all 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 results 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 (member) name
- Patient address
- Insured's Humana Healthy Horizons ID number: Be sure to provide the complete Humana Healthy Horizons member ID for the patient.
- Patient's birth date: Always include the member's date of birth so the correct member can be identified. (There may be more than 1 member with the same name).
- Place of service: Use standard CMS location codes.
- International Classification of Diseases, Tenth 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 member ID number section of this manual for more information.**
- 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 is 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 are 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 **provider relations representative** or **Availity Essentials**.

Corrected claims submission

When claims need updates or have errors during the initial submission, corrected claims can be submitted via paper claim or electronically. Providers have 365 calendar 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 **claim and encounter submissions.**

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 within 24 months of Humana's claims adjudication date are reprocessed. Providers are not required to resubmit the claim.

Contracted rate dispute process

Humana Healthy Horizons 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, as specified above
- Does not meet all 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**. These may also be mailed or emailed directly to **Avēsis**.

For all other providers, please submit claim contracted rate disputes to **contracted rate disputes** or via **Availity Essentials**.

Humana Healthy Horizons determines 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 calendar days of the original claim adjudication date. **For more information about appeals, please see the provider 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 non-covered services and provider types available in the **communications and network notices** section of the **Humana Healthy Horizons in Kentucky provider website**.

Kentucky DMS developed this list to allow providers to bill managed care organizations such as Humana Healthy Horizons 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 an Explanation of Medicare Benefits for appropriate coordination of benefits.

On receipt of Kentucky DMS updates to these lists, Humana Healthy Horizons analyzes the lists, initiates configuration and evaluates the updates based on Kentucky DMS changes. All updates are implemented and in effect 90 calendar days from our receipt of notice from Kentucky DMS.

Humana Healthy Horizons does not perform claims adjustments for previously paid claims based on Kentucky DMS updates to the Medicaid bypass lists for Medicare non-covered codes with retroactive dates, unless required by Kentucky DMS.

Copies of the bypass lists (in Excel format) are available online:

- **Provider type 30 ONLY**
- **All other provider types**

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 not covered outside of Medicaid. This list allows providers to bill Humana Healthy Horizons 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 **Humana Healthy Horizons' communications and network notices website**. As a reminder, the process allows providers to bill directly to Humana Healthy Horizons 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 contact **Provider Services**.

Provider payments

Humana Healthy Horizons utilizes 3 payment options for providers:

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

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.

EFT/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 that 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.
3. From the Applications tab, select the ERA/EFT Enrollment app. (If you do not 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 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**.

Virtual credit card payments

Humana Healthy Horizons partnered with PNC Healthcare and **ECHO® Health** to pay claims to eligible healthcare providers via VCC. We notify providers and organizations prior to their enrollment in virtual card payments, and participants may opt out of the program by contacting **ECHO Health, Inc.**

If you receive notification you were entered into the VCC program and you prefer to enroll in ERA/EFT instead, **please refer to the how to enroll in EFT/ERA payment section of this manual.** You must decline participation in the VCC program by calling **ECHO Health, Inc.** as soon as possible after receiving your VCC program notification.

VCC program participants 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 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, contact **ECHO Health Inc.**

Submitting electronic transactions

Availity Essentials

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

- Claim status
- Claim submission
- ERA/EFT
- Eligibility and benefits
- Member summary
- Overpayment
- Referrals and authorization
- Remittance advice
- Submission of disputes and appeals

For information regarding electronic claim submission:

- Contact **Provider Contracting.**
- Visit the **Humana claim submissions website**.
- Visit **Availity Essentials**.

Electronic data interchange clearinghouses

Electronic data interchange (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. **Availity Essentials** is Humana's preferred claims clearinghouse; however, providers can use other clearinghouses. Please contact the clearinghouse of your choice to begin electronic claim submission.

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

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

Some frequently used clearinghouses include **Availity Essentials**, **TriZetto**, **McKesson**, **Change Healthcare** and **SSI Group**. Please note that some clearinghouses and vendors charge a service fee. Please contact the clearinghouse directly for more information.

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 code sets when submitting healthcare claims electronically:

- ICD-10 Clinical Modification **(ICD-10-CM)**
    - Available in print from the **U.S. Government Publishing Office** and other vendors
- **Current Procedural Terminology (CPT)**
- **Healthcare Common Procedure Coding System (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.

NPI, TIN and taxonomy

Your NPI and TIN are required on all claims in addition to your provider taxonomy and specialty type codes (e.g., FQHC, RHC 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 with 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 contact **Provider Services**, **Provider Contracting** or **general correspondence** to update your demographic information.

Location of provider NPI, TIN and member 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 (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 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 member ID number should go on:

- 2010BA Loop = Subscriber name
- NM109 = Member 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 the **CMS-1500 Form** and the **UB-04 Form** are available online.

Paper claim forms can be mailed to **claim and encounter submissions.**

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.

Instructions for National Drug Code on paper claims

All 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 National Drug Code (NDC) excluding 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 3 spaces between the NDC and the units on paper forms.

Tips for submitting paper claims

- Electronic claims are processed more quickly than paper claims.
- No handwritten claims or super bills, including printed claims with handwritten information, are accepted.
- Use only original claim forms; do not submit claims that were 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 up to date and as it appears in the Kentucky DMS MPL, including TIN, billing and rendering NPI, addresses, and taxonomy codes.
- COB paper claims require a copy of the EOR 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 are 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, are 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 members in an emergency room setting)
- Emergency transportation, air ambulance only
    - When submitting air ambulance claims, please attach documentation that substantiates the member'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 member, 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 adjusts 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 is denied for timely filing.
- If a member has other insurance and Humana Healthy Horizons is secondary, the provider may submit for secondary payment within 6 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 was 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 member's primary carrier's payment information, including the COB indicator of either MA or MB for Medicare coverage and 16 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 dated no more than 180 calendar days from the primary payer's EOB date attached to each claim form involved, to verify that the original claim was received within 365 calendar days of the service date. COB paper claims require a copy of the EOR 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 elapses, the EOB must be submitted to us within 60 calendar 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 is denied for timely filing.
- The Medicaid bypass list for Medicare non-covered codes list and the commercial noncovered codes list are both **available online**.
- All claims for newborns must be submitted using the newborn's Humana Healthy Horizons member 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 calendar days. Do not submit newborn claims using the mother's identification numbers, as the claim is 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 a member's diagnosis was caused by the member's employment are not paid. The provider is 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 are not paid. All other revenue codes 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 claim guidelines and processing. **Please refer to the electronic visit verification section of this provider manual for more information.**
- A completed Kentucky Physicians Certification Statement Form for Non-Emergent Ground Transportation is required and must be submitted along with supporting clinical documentation with the affected 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 member treatments for which payment would otherwise be made. Claims indicating these conditions are not paid. If not submitting a claim, providers are subject to reporting the condition in writing to Kentucky 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 calendar days.
- Humana Healthy Horizons pays 99% of all claims submitted within 90 calendar 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 provides electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.
- Within 30 calendar days of receipt of a clean claim, Humana Healthy Horizons pays the claim or notifies 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 pays or denies the claim within 90 calendar days of receipt of the claim.

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

- Within 20 calendar days of receipt of the claim, Humana Healthy Horizons provides acknowledgment of receipt of the claim to the provider or designee or offers the provider or designee electronic access to the status of a submitted claim.
- Within 30 calendar days of receipt of the claim, Humana Healthy Horizons pays the claim or notifies 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 calendar days of receipt of the claim, Humana Healthy Horizons pays or denies 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 via **Availity Essentials**. Claim status is updated daily and provides information on claims submitted in the previous 24 months. You can search by member, claim number, service dates or HIPAA standards.

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 member's name, the date of service, the procedure code, service units, the reimbursement amount and identification of the specific Humana 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 KRS § 304.17A-730. Additionally, the same opportunity is extended to providers if a claim remains unpaid for more than 45 calendar days after the date the claim was received by Humana Healthy Horizons and claim or claims amount, individually or in aggregate, exceeds $2,500.

Code editing and payment policies

Humana Healthy Horizons processes accurate and complete provider claims in accordance with Humana's normal claims processing procedures, including, but not limited to, **Humana's claims processing edits** and **claims payment policies** and applicable state and/or federal laws, rules and regulations. Please see the **Humana healthcare providers website** to access a summary of changes to claims processing procedures; this summary of changes to claims processing procedures is not intended to be an exhaustive list.

Such claims processing procedures include review of the interaction of various factors. The result of Humana's claims processing procedures is dependent on factors reported on each claim. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures, but examples of the most used factors include:

- The complexity of a service
- Whether a service is one of multiple same-day services such that the cost of the service to the provider is less than if the service had been provided on a different day. For example:
    - 2 or more surgeries performed the same day
    - 2 or more endoscopic procedures performed the same day
    - 2 or more therapy services performed the same day
- Whether a co-surgeon, assistant surgeon, surgical assistant or any other provider who is billing independently is involved
- When a charge includes more than 1 claim line, whether any service is part of or incidental to the primary service provided, or if these services cannot be performed together
- Whether the service is reasonably expected to be provided for the diagnosis reported
- Whether a service was performed specifically for the member
- Whether services can be billed as a complete set of services under 1 billing code

Humana Healthy Horizons develops claims processing procedures at our sole discretion based on our review of correct coding initiatives, national benchmarks, industry standards and industry sources that include the following (including any successors of the same):

- Kentucky DMS regulations, manuals and other related guidance
- Federal and state laws, rules and regulations, including instructions published in the Federal Register
- National Uniform Billing Committee (NUBC) guidance, including the UB-04 Data Specifications Manual
- American Medical Association's (AMA's) Current Procedural Terminology (CPT®) and associated AMA publications and services
- CMS' HCPCS and associated CMS publications and services
- International Classification of Diseases
- American Hospital Association's (AHA's) Coding Clinic Guidelines
- Uniform Billing Editor
- American Psychiatric Association's (APA's) DSM and associated APA publications and services

- FDA guidance
- Medical and surgical specialty societies and associations
- Industry-standard utilization management criteria and/or care guidelines
- Our medical and pharmacy coverage policies
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published, peer-reviewed literature

Changes to any one of the sources may lead Humana Healthy Horizons to modify current or adopt new claims processing procedures.

These claims processing procedures may result in an adjustment or denial of reimbursement, a request for the submission of relevant medical records prior to or after payment, or the recoupment or refund request of a previous reimbursement.

An adjustment in reimbursement because of claims processing procedures is not an indication that the service provided is a non-covered service. Providers can submit a dispute request of any adjustment produced by these claims processing procedures by submitting a timely request to Humana. For additional information, **please refer to the provider grievance and appeals section of this manual.**

Providers are required to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. Claims indicating provider preventable conditions are not paid.

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.

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** and provide 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:

Provider type	Provider type no.
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

Provider type	Provider type no.
Certified community behavioral health clinics	16
Certified registered nurse anesthetist (CRNA)	74 749
Chiropractor	85 859
Community mental health centers	30
Comprehensive outpatient rehabilitation facilities	91
Dentist	60 61
Emergency transportation	55
EPSDT services – screenings	45
EPSDT services – special services	45
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

Provider type	Provider type no.
Physician services	65
Podiatry services	80 809
Primary care	31
Private duty nursing	18
Psychiatric distinct part unit	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	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

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). Kentucky DMS transitioned to EVV for 1915(c) HCBS waivers and HHCS as of Jan. 1, 2024. The use of EVV is a requirement of the Cures Act passed by the U.S. Congress in 2016.

EVV must electronically verify 6 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, including eliminating the need for paper documentation, creating flexibility in scheduling and delivering services, improving participant health monitoring, safety and welfare, and reducing potential Medicaid fraud, waste and abuse.

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

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 calendar 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 sustains 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 provider's claim payments are subject to suspension when 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 payment. A

remittance advice is issued to the provider that states, “Payment has been placed in escrow, per state regulations.”

Coordination of benefits

Humana Healthy Horizons collects coordination of benefits (COB) information for our members. 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 many sources for information updated periodically, and some updates may not always be fully reflected on our provider portal. Please ask Humana Healthy Horizons-covered patients for all healthcare insurance information at the time of service.

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

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

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

Claims involving COB are not paid until an EOB/EOR or EDI payment information file is received that indicates 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 refer to 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 calendar 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 **coordination of benefits (COB) overpayment**.

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

Member billing

Providers should collect copayments from members when applicable, as copayment amounts are subtracted from claim payments for services. **Please refer to the copayment section of this provider manual for more information.**

State requirements and federal regulations prohibit providers from billing Humana Healthy Horizons-covered patients for medically necessary covered services except under extremely limited circumstances. Providers who knowingly and willfully bill a member 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 members. 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 members harmless in the event Humana Healthy Horizons does not pay for a covered service performed by the provider. Members cannot be billed for services that are administratively denied. The only exception is if a Humana Healthy Horizons member 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 member 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** for guidance before billing members for services.

Missed appointments

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

Humana Healthy Horizons encourages the use of the Kentucky DMS No Show Appointment Tool to document missed appointments. The dashboard can be accessed via the **KYMMIS** site in the KYHealthNet application under DMS Reports.

Member termination claim processing

From Humana Healthy Horizons to another plan

In the event of a member's termination 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:

- On daily receipt of the 834-eligibility file from Kentucky DMS, Humana Healthy Horizons identifies which members received a retroactive eligibility date and require termination of enrollment within the Humana Healthy Horizons claims payment system.
- Humana Healthy Horizons initiates the member termination process. This is completed within 5 business days of receipt of the 834 file.
- Humana Healthy Horizons determines whether claims were paid for dates of service in which the member was afterward identified as ineligible for Medicaid benefits with Humana Healthy Horizons. This process is completed within 5 business days.
- 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.
- Once the 30-calendar-day limit expires, if the affected provider did not attempt to appeal the recoupment of payment or did not submit a refund check before 30 calendar days expired, Humana Healthy Horizons adjusts the payment(s) for the affected claims listed in the notice letter. This takes place within 10 business days.
- The provider receives an EOR reflecting the funds recouped. This takes place within 5 business days of completion of payment adjustment(s).
- 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 that if the original encounter was denied or rejected by Kentucky DMS, a void does not need to occur.
- 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 member's current active Medicaid plan. The courtesy letter is sent within 5 business days. Please note that if 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 calendar days of the issued EOR reflecting recoupment of payments and the issued courtesy letter, Humana Healthy Horizons encourages providers to contact the member's current Medicaid managed care plan for the claim(s) dates of service.

From another plan to Humana Healthy Horizons

If a member was previously enrolled with another Medicaid plan and is now eligible with Humana Healthy Horizons, providers are required to submit a copy of the EOR reflecting recoupment of payment and documentation from the previous MCO to validate that 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 calendar days from the date of the accepted voided encounter to submit the claim to Humana Healthy Horizons to avoid timely filing denials. Providers can submit these claims to **Provider Grievance and Appeals**.

Humana Healthy Horizons sends an acknowledgement letter within 5 business days of the receipt of the appeal. If the appeal request was received by telephone, the acknowledgement letter includes 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 2 calendar days of the reason for the decision to extend the time frame. We also inform the member 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 member or someone chosen by the member can:

- Review all the information used to make the decision
- Provide more information throughout the appeal review process
- Examine the member'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 on or generated in connection with the appeal.
    - This information is provided, on request, free of charge and sufficiently in advance of the resolution time frame.

If the member or their appointed representative feels waiting for the 30-day time frame to resolve an appeal could seriously harm the member'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 member'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 member's health. Negative actions will not be taken against a member or provider who files an appeal or a provider who supports a member's appeal or files an appeal or expedited appeal on behalf of a member with written consent.

State fair hearings

Members 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 calendar days of the date on the Humana Healthy Horizons appeal decision letter. Contact **state fair hearings** for more information.

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

Members with an urgent health condition can ask for an expedited hearing. If the hearing finds that Humana Healthy Horizons' decision was correct, the member 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, members can request to continue services during the appeal and Medicaid state fair hearing process. Continued services must be services the member already receives, including those services that are reduced or terminated.

Humana Healthy Horizons continues services if an appeal is requested within 10 business 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. Member benefits continue until one of the following occurs:

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

If the appeal was denied and a request for a Medicaid state fair hearing with continuation of services is received within 10 business days of the date on the appeal resolution letter, the services continue during the Medicaid state fair hearing.

Please refer to the member grievance and appeals section of this provider manual for more information.

However, if the first decision to deny the service is upheld, the member may be required to pay for these services.

Chapter 14: Case management

Humana Healthy Horizons provides comprehensive and integrated care management services through medical and behavioral health staff, social workers and outreach specialists, including one-on-one personal interaction and support for members. Additionally, Humana Healthy Horizons coordinates with community-based resources to mitigate the effects of SDOH, including food security services, transportation to medical appointment services and utilities payment support. To help members who need assistance with SDOH, please contact **population health**.

Our 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 members, reinforcing medical instructions and assessing social needs. We also offer a care management program designed to educate pregnant women and first-time mothers on the importance of prenatal, childbirth, postpartum and infant care.

Care management and care coordination

Humana Healthy Horizons members have access to care managers who provide a holistic approach to addressing a member's physical and behavioral healthcare needs as well as SDOH. We also offer chronic condition management programs for behavioral health and SUDs. Humana Healthy Horizons-contracted providers may contact us to refer members needing care management assistance by calling **Care/Case Management**. Humana Healthy Horizons adheres to a "no wrong door approach" to care management referrals.

Behavioral health service providers are required to refer members with known or suspected and/or untreated physical health problems or disorders to their PCP for examination and treatment, with the member's or the member'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 member'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 member's PCP and to refer members for PCP follow-up on untreated physical health concerns when identified. **For further information about our integrated care management programs, please refer to the member support services and benefits section of this manual.**

Referrals to care management

We encourage you to refer members who might need individual attention to help them manage special healthcare challenges to our care management programs. For direct access, please contact **Care/Case Management**, **population health** or the **HumanaBeginnings maternity program**.

Care management services

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 members from their initial assessment through the continuum of care with the goal for members to take an active part in their healthcare and make healthy lifestyle decisions. We take a member-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 barriers to care and keeping appointments. When necessary, we assist in arranging transportation to the provider's office.

Humana Healthy Horizons 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 patient's

multidisciplinary care team. We believe communication and coordination are integral to ensure the best care for our members. Please contact **Care/Case Management** for care management referrals and assistance with member needs.

Disease management programs

Humana Healthy Horizons members with emerging conditions and those with chronic conditions are eligible for enrollment in our **disease management** programs. Members 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. Members identified as high risk are assigned a medical or behavioral health clinician who helps educate, coordinate and provide resources to the member to optimize their overall health.

Chronic and emerging conditions include:

- Asthma
- Chronic obstructive pulmonary disorder (COPD)
- Heart disease
- Diabetes
- Obesity
- Cancer
- Behavioral health and SUD
- Members with special healthcare needs
- And others, as determined by Humana Healthy Horizons

If you have Humana Healthy Horizons-covered patients with any of these chronic conditions and you believe they would benefit from this program, please contact **Care/Case Management**.

High-risk members

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

High-risk members often have multiple medical issues, socioeconomic challenges and behavioral healthcare needs. Our Humana Healthy Horizons multidisciplinary care management teams are led by experienced care managers who perform a comprehensive assessment with the member. 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 to update the care plan as needed based on member needs and preferences. Your patient's care plan is viewable via **Availity Essentials** or by requesting a copy from **Care/Case Management**.

Prenatal care management

Humana Healthy Horizons offers 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 members. Our staff expertise includes a focus on patient education and support and involves direct telephone contact with members and providers. Humana Healthy Horizons encourages our prenatal care providers to notify **Care/Case Management** when a member with a high-risk pregnancy is identified.

Notification of Pregnancy Form

Humana Healthy Horizons is committed to help providers manage high-risk pregnancies. Humana Healthy Horizons requests prenatal care providers use the **Notification of Pregnancy (NOP) form** to communicate critical information about our pregnant members. This information is made available to the Humana Healthy Horizons Care Management team for outreach to members as necessary.

Please remember the following guidelines when submitting NOP:

- Use the designated **NOP form**.
- Send completed forms no later than 4 weeks after the member's first prenatal visit.
- Be sure to include the member's estimated delivery date (EDD) on the form.

You may use the NOP form located on **Humana Healthy Horizons' website**. We accept copies or originals of NOPs via fax or email. Please send them to the **HumanaBeginnings maternity program**.

Humana Healthy Horizons accepts up to 3 assessment forms per pregnancy if additional forms are needed for changes noted during subsequent visits.

Equitable population health management

Humana Healthy Horizons puts 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 Healthy Horizons' enterprise mission and a core component of our managed care programs. Humana Healthy Horizons assesses members to identify needs and preferences, employs strategies to improve health and well-being, and implements interventions for priority populations—members 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 Healthy Horizons knows providers have a huge role in helping us achieve the triple aim through population health, and increasing providers' equitable population health management capabilities requires access to accurate, actionable data. Humana Healthy Horizons 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.

Compass

Humana's proprietary population health platform, **Population Insights Compass**, is a valuable tool for providers. Providers can **request access** through their Humana Healthy Horizons **provider relations** representative. Through our 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 Humana Healthy Horizons-covered patients and better inform their outreach and care.

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

- Quality reports based on NCQA guidelines identify opportunities to improve care for affected patients. These reports give providers an actionable breakdown of opportunities in care by member, with specific noncompliance reasons and suggested calls to action to aid providers. Quality reports also include a detailed, comprehensive view of Humana members with diabetes, including nephropathy tests, body mass index (BMI) changes and medication adherence. HEDIS analyses and opportunities for improved care are updated weekly.

- Census reports identify all attributed patients who are currently admitted into an inpatient care facility. They also identify

members recently discharged from inpatient care. These analyses are updated daily.

- Patient detail reports provide an in-depth look at each member, including demographics, visit history, diagnoses, HEDIS opportunities for care, authorization, 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 Clinical dashboard available to external provider access users.

Phone book and other contact information

Contact	Phone	Hours	Other information
Availity Essentials	800-282-4548	Monday – Friday, 8 a.m. – 8 p.m., Eastern time	Customer service/technical support information for Humana Healthy Horizons' secure provider portal, **Availity Essentials**
Avēsis	Dental: 888-211-0599 Vision: 844-511-5760	Dental: Monday – Friday, 7 a.m.– 7 p.m., Eastern time	This is the contact information for Avēsis, Humana Healthy Horizons' third-party administrator for dental and vision services. Please see the **Avēsis provider portal**. Mail: Avēsis Third-Party Administrators, Inc. Complaint Appeals and Grievances P.O. Box 38300 Phoenix, AZ 85069-8300 Fax: 855-691-3243 Email: **ag@avesis.com**
Behavioral health crisis line	833-801-7355	24 hours a day, 7 days a week	Humana Healthy Horizons' behavioral health crisis line
Behavioral Health Services	888-666-6301 (TTY: 711)		Telephone number for nonemergency Humana Healthy Horizons behavioral health services
Cabinet for Health and Family Services (CHFS) Division of Family Support (DFS)	855-306-8959	Monday – Friday, 8 a.m. – 4:30 p.m., Eastern time; Saturday, 9 a.m. – 2 p.m., Eastern time	CHFS DFS can be reached via telephone, mail or **online**. Mail: Cabinet for Health and Family Services Division of Family Support P.O. Box 2104 Frankfort, KY 40602-2104
Care/Case Management	888-285-1121	Monday – Friday, 8 a.m. – 6 p.m., Eastern time	Care/case management support is available by telephone, email or fax. Email: **KYMCDCaseManagement@humana.com** Fax: 833-939-1312
Change Healthcare (clearinghouse)	800-792-5256		**Change Healthcare** is one of several different clearinghouses you may consider using for filing claims electronically with Humana Healthy Horizons. Additional support is available via telephone.
CHFS general information and ombudsman	800-372-2973	Monday – Friday, 8 a.m. – 5 p.m., Eastern time	The CHFS general information and ombudsman can be reached via telephone.

Contact	Phone	Hours	Other information
Claim and encounter submissions			Providers can submit claims and encounters electronically or on paper. Electronic claim submissions can be made via Availity Essentials. Humana Healthy Horizons medical claims, dental claims and encounters can be submitted via mail. Humana medical claims submit via mail to: Humana Claims P.O. Box 14601 Lexington, KY 40512-4601 Avēsis Third Party Administrators, Inc. Dental Claims P.O. Box 38300 Phoenix, AZ 85069-8300 Fax: 855-691-3243 Email: **ag@avesis.com**
Claims Research and Resolution Team		Monday – Friday, 8 a.m. – 5 p.m., Eastern time	Email: **KYMCDCRR@humana.com**
Communication assistance, interpreters and alternative formats	877-320-2233	Daily, 8 a.m.– 8 p.m., Eastern time	Humana Healthy Horizons provides over-the-phone interpretation in over 150 languages at Humana touchpoints. Humana Healthy Horizons also provides TTY and alternative formats including braille, large print, audio, DAISY, screen reader accessible PDF and reading over the phone of your written communications. American Sign Language (ASL) interpreters are available in person or via video. Additional communication assistance support is detailed on our member **communication assistance website**, or accessible via phone call or email. Email: **accessibility@humana.com**
Contracted rate disputes			Providers can submit contracted rate disputes to Humana Healthy Horizons via mail, fax, Availity Essentials or Avesis.. Mail: Humana Healthy Horizons P.O. Box 14546 Lexington, KY 40512-4546 Fax: 800-949-2961

Contact	Phone	Hours	Other information
Coordination of benefits (COB) overpayment			Coordination of benefits overpayments can be sent via mail to Humana Healthy Horizons. Mail: Humana P.O. Box 931655 Atlanta, GA 31193-1655
Council for Affordable Quality Healthcare (CAQH)			CAQH **provider data portal**
Credentialing and recredentialing			Credentialing and recredentialing inquiries can be directed via mail, fax or email to Humana Healthy Horizons. Mail: Humana Healthy Horizons in Kentucky Attn: Credentialing 101 E. Main St. Louisville, KY 40202 Fax: 502-508-0521 Email: **CredentialingInquiries@humana.com**
Current Procedural Terminology (CPT)			More information about CPT coding is available on the American Medical Association's **CPT website.**
Department for Community Based Services (DCBS) county office location tool			Use the **kynect website** to find **DCBS county office locations.**
Disease management	888-285-1121	Monday – Friday, 8 a.m. – 6 p.m., Eastern time	Humana Healthy Horizons' disease management support is available via phone or email. Email: **KYMCDCaseManagement@humana.com**
ECHO Health, Inc.	888-483-9212	Monday – Friday, 8 a.m. – 6 p.m., Eastern time	ECHO Health, Inc. provides virtual credit card payment solutions for providers. More information is available on the **ECHO Health, Inc. website** or via telephone.
Ethics Helpline	877-5-THE-KEY (584-3539)		Humana's hotline for reporting fraud, waste and abuse.

Contact	Phone	Hours	Other information
EviCore healthcare (healthcare partner)	866-672-8115	Monday – Friday, 7 a.m. – 7 p.m., Eastern time	EviCore healthcare is a Humana Healthy Horizons partner managing prior authorization for advanced imaging services, physical therapy (PT), occupational therapy (OT) and speech therapy (ST). EviCore healthcare can be reached via telephone or fax. Fax: Advanced imaging services: 800-540-2406 PT/OT/ST: 855-774-1319
Evolent Health	855-427-1372, option 1	Monday – Friday, 8 a.m. – 8 p.m., Eastern time	Evolent Health is a Humana Healthy Horizons partner managing prior authorization for chemotherapy and other supportive agents. More information is available on the **Evolent Health website,** via fax or by phone. Fax: 833-974-0059
General correspondence			General correspondence for Humana Healthy Horizons can be mailed. Mail: Humana Healthy Horizons P.O. Box 14601 Lexington, KY 40512-4601
Healthcare Common Procedure Coding System (HCPCS)			More information about HCPCS coding is available on the CMS **HCPCS Level II Coding Procedures website**.
HumanaBeginnings maternity program	888-285-1121 (TTY: 711)	Monday – Friday, 8 a.m. – 6 p.m., Eastern time	The HumanaBeginnings maternity program can be reached via telephone, **online**, fax or email. Fax: 833-939-1317 Email: **KyMCDHumanaBeginnings@humana.com**
Incarceration status correction	800-444-9137 (TTY: 711)	Monday – Friday, 7 a.m. – 7 p.m., Eastern time	Please contact Medicaid Member Services via telephone for support with incarceration status correction. Fax: 502-564-0039
Kentucky CHFS customer service	800-635-2570	Monday – Friday, 8 a.m. – 5 p.m., Eastern time	Kentucky CHFS customer service line is available by telephone.
Kentucky CHFS provider services	855-824-5615	Monday – Friday, 8 a.m.– 5 p.m., Eastern time	Kentucky CHFS provider services are available via telephone or **online**.

Contact	Phone	Hours	Other information
Kentucky CHFS reporting	800-372-2970	Monday – Friday, 8 a.m. – 4:30 p.m., Eastern time	This contact can be used to report Medicaid fraud, waste and abuse.
Kentucky Health Information Exchange	800-633-6283		Support for the KHIE is available **online**, via telephone or via email. Email: **KHIESupport@ky.gov**
KYHealthNet			**KYHealthNet** is the commonwealth's web portal that offers real-time member eligibility access and MCO enrollment information.
Kynect			**Kynect website**
McKesson (clearinghouse)	800-782-1334		**McKesson** is one of several different clearinghouses you may consider using for filing claims electronically with Humana Healthy Horizons. Additional support is available via telephone.
Medication Intake Team	866-461-7273	Monday – Friday, 8 a.m. – 11 p.m., Eastern time	Prior authorization for medications administered in a provider setting can be submitted **online** or via fax. Prior authorization and notification lists are also **available online**. The Medication Intake Team can be reached via phone or fax: Fax: 888-447-3430
MedImpact	800-210-7628	24 hours a day, 7 days a week	MedImpact manages all prior authorization for drugs under the pharmacy benefit (drugs dispensed to the member by a pharmacy). To submit a PA request: • Call MedImpact at 844-336-2676 • Fax the request to 858-357-2612 • Use the **CoverMyMeds®**, **Surescripts®** or **CenterX® ePA** online portals. To submit a pharmacy paper claim: • Fax MedImpact at 858-549-1569 To reach the technical call center: • Call MedImpact Additional information is available on the **MedImpact website** as well.
Member Grievance and Appeals	800-444-9137 (TTY: 711)		Member grievances with Humana Healthy Horizons can be submitted in writing or via fax. Mail: P.O. Box 14546 Lexington, KY 40512-4546 Fax: 800-949-2961

Contact	Phone	Hours	Other information
Member Services	800-444-9137 (TTY: 711)	Monday – Friday, 7 a.m. – 7 p.m., Eastern time	Please refer Humana Healthy Horizons in Kentucky members to the Member Services line for their inquiries.
National Drug Codes			The National Drug Code directory is available **online**.
Nonemergency medical transportation (NEMT)	888-941-7433	Monday – Friday, 8 a.m. – 4:30 p.m., Eastern time; Saturday, 8 a.m. – 1 p.m., Eastern time	Medicaid covers medically necessary transportation to and from a Medicaid-covered service, as described on the **CHFS website**. Nonemergency medical transportation can be arranged via telephone. Additional information about transportation is available on the **human services transportation website**.
Nurse Advice Line	800-648-8097	24 hours a day, 7 days a week	Members can reach a nurse for advice 24 hours a day, 7 days a week via our Nurse Advice Line.
Office for Civil Rights	800-368-1019 TTY: 800-537-7697	Monday – Friday, 8 a.m. – 6 p.m., Eastern time	The U.S. Department of Health and Human Services Office for Civil Rights can be reached via telephone, fax or mail. Mail: Sam Nunn Atlanta Federal Center 61 Forsyth Street S.W. Suite 16T70 Atlanta, GA 30303-8909 Fax: 202-619-3818
Pharmacy lock-in program	855-330-8054	Monday – Friday, 8 a.m. – 5:30 p.m., Eastern time	Support for the Humana Healthy Horizons pharmacy lock-in program is available via telephone.
Population health	866-331-1577	Monday – Friday, 8 a.m. – 5:30 p.m., Eastern time	Humana Healthy Horizons' population health (social determinants of health; SDOH) support is available via telephone or email. Email: **KYMCDPopulationHealth@humana.com**
Population Insights Compass			An **online FAQ document** was compiled for providers seeking access to the Population Insights Compass program.
Prior authorization (PA) assistance	800-444-9137 (TTY: 711)	Monday – Friday, 8 a.m. – 6 p.m., Eastern time	Assistance for prior authorization requests related to medical procedures and behavioral health is available via telephone.
Provider Contracting			Please reach out via email for Humana Healthy Horizons provider contracting inquiries. Request to join the network via the following: Email (physical health): **ProviderDevelopmentKYWV@humana.com**

Contact	Phone	Hours	Other information
			Email (behavioral health): **KYBHMedicaid@humana.com**
Provider documents and resources			Additional information is available for Kentucky providers on Humana Healthy Horizons' **provider documents and resources website**.
Provider Grievance and Appeals	800-444-9137 (TTY: 711) if an expedited grievance and appeal process is required		Provider grievances with Humana Healthy Horizons can be submitted online, via mail or fax. Expedited grievance and appeal requests should be submitted via telephone. Submit online: **Online grievance or appeal reporting form** Print and mail: **Grievance or appeal reporting form for printing** Humana Healthy Horizons in Kentucky Grievance and Appeal Department P.O. Box 14546 Lexington, KY 40512-4546 Fax: 800-949-2961
Provider Relations			Provider relations inquiries can be submitted via email. Email: **KYMCDPR@humana.com**
Provider Services	800-444-9137	Monday – Friday, 8 a.m. – 6 p.m., Eastern time	Humana Healthy Horizons provider services are available via telephone or on our **Humana Healthy Horizons in Kentucky provider website**.
Provider status changes			Please send provider status changes to Humana Healthy Horizons via email. Email: **ProviderDevelopmentKYWV@humana.com** Behavioral health ONLY email: **KYBHMedicaid@humana.com**
Quality Improvement			Quality improvement concerns can be submitted to Humana Healthy Horizons via mail. Mail: Humana Healthy Horizons Quality Improvement 101 E. Main St. Louisville, KY 40202
Reconsideration of credentialing/recredentialing			Requests for Humana Healthy Horizons to reconsider credentialing or recredentialing decisions can be submitted via mail to our regional medical director.

Contact	Phone	Hours	Other information
decisions			Mail: Humana Healthy Horizons Attn: Jennifer Moncrief, M.D. 101 E. Main St. Louisville, KY 40202
Special Investigations Unit (SIU)	Direct line: 800-558-4444, ext. 1500724 Hotline: 800-614-4126	Direct line: Monday – Friday, 8 a.m. – 5:30 p.m., Eastern time Hotline: 24 hours a day, 7 days a week	The Special Investigations Unit serves as a reporting organization for fraud, waste and abuse. SIU support is available via telephone, mail, or **online**. Mail: Humana Special Investigations Unit 1100 Employers Blvd. Green Bay, WI 54344 Email: **SIUReferrals@humana.com**
SSI Group (clearinghouse)	800-820-4774		The **SSI Group** is one of several different clearinghouses you may consider using for electronically filing claims with Humana Healthy Horizons. Additional support is available via telephone.
State fair hearings	800-635-2570		Kentucky Department for Medicaid Services Division of Program Quality and Outcomes 275 E. Main St. 6C-C Frankfort, KY 40621 Fax: 502-564-0223 Email: **DMS.Hearings@ky.gov**
TriZetto (clearinghouse)	800-556-2231		**TriZetto** is one of several different clearinghouses you may consider using for filing claims electronically with Humana Healthy Horizons. Additional support is available via telephone.
U.S. Government Publishing Office (for ICD-10-CM)	202-512-1800	Monday – Friday, 8 a.m. – 5:30 p.m., Eastern time	For information related to the ICD-10-CM, please contact the U.S. Government Publishing Office via telephone or fax. Fax: 202-512-2250
Utilization Management: behavioral services			Support for Utilization Management requests related to behavioral health services should be submitted via email. Email: **KYMCDBehavioralHealthUM@humana.com**
Utilization Management: medical services	800-444-9137	Monday – Friday, 7 a.m. – 7 p.m., Eastern	Support for Utilization Management requests related to medical services can be submitted via phone, email or fax.

Contact	Phone	Hours	Other information
		time	Email: **KYMCDMedicalUM@humana.com** Fax: 833-974-0059
Vaccines for Children program			Information about the CDC's Vaccines for Children program is available **online**. Information about Kentucky's Vaccines for Children program is also available **online**.
WholeHealth Living (a brand of Tivity Health)	800-274-7526	Monday – Friday, 8:30 a.m. – 5:30 p.m., Eastern time	WholeHealth Living is a Humana Healthy Horizons partner supporting prior authorization for chiropractic services. More information is available on the **WholeHealth Living website,** via fax or by telephone. Fax: 888-492-1025