Humana Healthy Horizons in Kentucky Policies Booklet

For providers who render services to our Humana Healthy Horizons® in Kentucky-covered patients, please review the important policies information contained within this document.

Please note:

Providers are solely responsible for submission of accurate and complete claims that comply with state and federal billing guidelines and regulations. These policies seek to provide, among other items, information on services that may require additional guidance to improve the quality of the services billed. References to procedure codes and/or specific services do not imply any right to reimbursement. Humana Healthy Horizons reserves the right of reasonable interpretation in applying service coverage policies. In addition, not all aspects of the services referenced are included in this policy and therefore may/will be subject to additional coverage criteria and/or billing requirements. Other factors may affect final reimbursement of covered services; Humana Healthy Horizons retains the right to modify said policies as needed and publish them accordingly, pursuant to state regulations.

For more information, please visit:

Clinical coverage policy

The **Clinical Coverage Policy** site outlines certain medical and behavioral health services that Humana Healthy Horizons covers and describes how clinical reviews for member care are handled, especially when standard Milliman Care Guidelines (MCG) aren't specific.

Claims payment policy

Humana shares its **medical claims payment policies online** to help healthcare providers and their billing offices understand how claims are paid and billed, which can reduce delays and eliminate extra paperwork.

Code edit rules

Humana updates its claim processing rules to include new or changed medical codes as needed. Updates may occur without prior notice; this lack of notification also applies to new codes for drugs and biosimilars. For more information, please visit our **claims and code edits web page**.

Humana
Healthy Horizons®
in Kentucky

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Disclaimer

State and federal law, as well as contract language that includes definitions and specific inclusions/exclusions, drives claim coverage policies and are used when determining criteria for claim coverage. Claim coverage also may differ based on all applicable Kentucky Department for Medicaid Services (DMS) and Centers for Medicare & Medicaid Services (CMS) coverage guidelines, national coverage determinations, local medical review policies, and/or local coverage determinations. Please refer to CMS' website for additional guidance. Claim coverage policies are not intended to preempt the judgment of the reviewing medical director or dictate to healthcare providers how to practice medicine. Healthcare providers are expected to exercise their medical judgment to render appropriate care. Identification of brand-name devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Clinical technology is constantly evolving, and we reserve the right to review and update this policy periodically.

Document change log

Date	Policy	Comments
3/26/2026	Intensive Outpatient Program Services claim payment policy	Updated process
3/26/2026	Out-of-network provider requirements and claim payment policy	Updated Process
2/2/2026	Notice Completion, Retention and Claim Submission	Updated process
1/30/2026	IMD Requirements	Added to booklet
1/30/2026	Cell and Gene Therapy (CGT) Access Model	Updated process
1/30/2026	Neonatal Intensive Care Unit (NICU) Claims Payment	Updated process
12/23/2025	Outpatient Drug Reimbursement Policy	Added to booklet
11/6/2025	Bypass for commercial codes	Updated process
11/6/2025	Behavior Health duplication of services policy	Added to booklet
10/9/2025	Bypass for Medicare Codes	Updated process
10/9/2025	Incontinent Supply Reimbursement	Added to booklet
10/9/2025	Appeal Time Frame	Added to booklet
8/11/2025	Vaccines for Children (VFC) billing modification	Added to booklet
7/10/2025	Psychoeducation Claims covered Service Limitation Policy	Added to booklet
7/1/2025	Expanded retrospective review policy – revised August 2024	Added to booklet
6/4/2025	Peer Support Claims Covered Services Limitation Policy	Added to booklet
1/1/2025	Senate Bill 111 Treatment of Stuttering	Added to booklet

Hyperlink list of Humana Healthy Horizons in Kentucky policies:

Ambulatory surgical center (ASC) bundled services — 3/1/24

Anesthesia modifier billing — 7/1/22

Annual sports physical exam — 7/6/23

Appeal Time Frame — 10/9/25

Behavioral Health duplication of services policy — 2/1/26

Bypass for Commercial Codes — 11/6/25

Bypass for Medicare Codes — 10/9/25

Cell and Gene Therapy (CGT) Access Model — 1/1/26

Claim submission requirements update — 12/1/20

Emergency department E/M reimbursement — 7/23/23

Expanded retrospective review — 8/1/24

Facility and Non-Facility NA Indicator

Fee schedule — 8/14/23

IMD requirements — 1/15/26

Incontinent Supply Reimbursement — 10/9/25

Intensive Outpatient Program Services claim payment policy — 4/1/26

Kentucky Medicaid Regulation: 902 KAR 2:020 Reportable Disease Surveillance — 1/1/21

Laboratory tests with or without comprehensive tests — 1/1/24

Long-Acting Reversible Contraception While Inpatient Postpartum — 7/11/24

Medicaid Physicians Certifications Statement (PCS) Form for Non-Emergent Ground Transportation — 1/1/24

Medicaid Provider External Independent Review (EIR) Intake Form — 10/1/24

Medical Supplies, Equipment, and Appliance (MSEA) Rental — 3/1/24

Modifier 52 & 53 billing — 3/1/24

Modifier 52 (Revised)

Modifier 53

Modifier 78 billing — 3/1/24

Multiple Evaluation and Management (EM) Services — 6/18/24

National Drug Code Billing Requirement — 2/25/15

Neonatal Intensive Care Unit (NICU) claims payment — 7/11/25

Outpatient Drug Reimbursement Policy — 4/1/26

Out-of-network provider requirements and claim payment policy - 3/26/26

Peer Support Claims Covered Services Limitation Policy — 7/5/25

Psychoeducation Claims covered Service Limitation Policy — 7/5/25

Physician Administered Drugs — 4/20/21

Required Forms: Notice Completion, Retention and Claim Submission — 2/2/26

Senate Bill 111 Treatment of Stuttering — 1/1/25

Sexually transmitted infection testing — 1/1/24

Status B Codes — 6/8/24

SUD 1115 Waiver billing requirements — 11/1/22

Urine drug testing — 7/1/20

Vaccines for Children (VFC) billing modification — 8/11/25

Venipunctures, evaluation and management (EM) services — 3/1/24

Viral hepatitis serology — 1/1/24

Vitamin D testing — 1/1/24

Out-of-network provider requirements and claim payment policy — 3/26/2026

For providers who are not in our network but serve Humana Healthy Horizons® in Kentucky-covered patients, please review the important information below regarding Kentucky Department for Medicaid Services (DMS) enrollment, Humana Healthy Horizons' out-of-network claim payment policy and Humana Healthy Horizons' contracting contacts.

Kentucky DMS provider enrollment

Payment for services furnished to a Humana Healthy Horizons member will be made only if all providers (referring, treating, rendering, billing, ordering, prescribing and nonparticipating) are enrolled with Kentucky DMS. If you are not currently an enrolled provider, Humana Healthy Horizons can assist you. Please send an email to ProviderMedicaidEnrollment@humana.com for assistance with the enrollment process.

Out-of-network claim payment policy

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.

Exceptions:

Maternity services, including up to 60 days postpartum, do not require prior authorization.

Physical Therapy, Occupational Therapy and Speech Therapy, habilitation and rehabilitation services, do not require prior authorization for the first 20 visits rendered per modality in each calendar year. This applies to the following providers: multi-therapy agency; a comprehensive outpatient rehabilitation facility; a mobile health service; a special health clinic; or a rehabilitation agency. The 20 visit limit does not apply to specific therapy diagnoses and diagnosis codes as established pursuant to **907KAR8:040 section 2.(3)(f)** as they do not require prior authorization. (Please note these two exceptions do not apply to **Early and Periodic Screening, Diagnosis, and Treatment Special Services, Provider Type 45**.)

Nonemergency ambulance services may be preauthorized or billed with a completed Kentucky Physicians Certification Statement of Medical Necessity. This form can be found at **Humana Healthy Horizons in Kentucky provider documents and resources.**

The following are exceptions to the preauthorization requirement and out-of-network reimbursement guidelines. These services are reimbursed at 90% of the Kentucky Medicaid fee schedule:

- Services provided for family planning
- Services for children in foster care
- Emergency care (nonparticipating professional and facility services provided to members in an emergency room [ER] setting)
- Emergency medical transportation
- **Note:** When submitting air ambulance claims (procedure codes A0430 and A0431), 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.

  Claims with medical records that support medical necessity for air transport are reimbursed at 90% of the Kentucky Medicaid fee schedule. Claims billed with documentation that does not support the medical necessity for urgency of air transport are paid at 65% of the Kentucky Medicaid fee schedule.

Claims billed with no documentation or documentation indicating air transport was not medically necessary are denied.

The following is reimbursed at 100% of the Kentucky Medicaid fee schedule and requires no prior authorization effective Nov. 1, 2022:

- Pharmacy provider (provider type 54) billing for vaccine counseling via medical benefit (CMS-1500/837P) for Current Procedural Terminology (CPT®) code 99401
- Effective Jan. 1, 2026, Sickle Cell Disease (SCD) Cell and Gene Therapy (CGT) Access Model prescription drugs Casgevy and Lyfgenia are reimbursed as outlined in 907 KAR 023:020. SCD therapy-related care provided to Model beneficiaries up to 365 days post-infusion is reimbursed at 100% of the Kentucky Medicaid fee schedule and requires no prior authorization. Specific to transportation services covered by the MCO, transportation related to this treatment will be paid at 100% of the Kentucky Medicaid fee schedule.

Healthcare Common Procedure Coding System code H2027 is an exception to the reimbursement policy and is paid at a flat rate of $7, regardless of modifier billed.

The following preauthorized medically necessary services are exceptions to the reimbursement policy:

- G-codes G0480, G0481, G0482, G0483 and G0659 will be reimbursed at a $40 flat rate.
- All other laboratory services, including reference/clinical laboratory services, will be reimbursed at 45% of the Kentucky Medicaid fee schedule.

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. If a modification to the Kentucky DMS fee schedule is the addition of a new code or modifier, Humana Healthy Horizons will adjust previously adjudicated claims impacted by such a modification in accordance with any applicable retroactive effective date.

Contracting contacts

If you are interested in joining Humana Healthy Horizons' network, visit our website at **Join our network**.

IMD Requirements — 1/15/2026

Humana Healthy Horizons in Kentucky covers short-term stays in an institution for mental disease (IMD) pursuant to the Kentucky Department for Medicaid Services policy "**Kentucky Medicaid Section 1115 Serious Mental Illness (SMI) Implementation**" dated December 10, 2025. As a reminder, Humana Healthy Horizons now processes these claims for payment as indicated by the department's policy, per the provider's Humana Healthy Horizons contract agreement and/or the out of network payment policy. IMD admissions on or after January 15, 2026, that exceed 60 days are denied.

Short-term stays in an IMD are subject to prior authorization. Emergent services are the only exception.

Humana reserves the right to initiate overpayment recovery of claims identified as overpaid pursuant to the Kentucky DMS reimbursement guidelines and the Medicaid Managed Care Contract.

Providers may appeal the claim denial. 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 denial to file an appeal. For more information on appeals, please refer to the **Kentucky Medicaid Provider Manual**.

Status B Codes — 6/18/2024

This Kentucky Medicaid policy outlines Humana's reimbursement for status B codes.

Please review the claims payment policy at **Humana.com/ClaimsPaymentPolicies**. Enter Status B in the keyword search and look for Status B Codes, effective 6/18/2024.

Physician Administered Drugs — 4/20/2021

This Kentucky Medicaid policy outlines how Humana establishes rates for Physician Administered Drug codes that do not have rates in the Kentucky Medicaid fee schedule.

Please review the claims payment policy at **Humana.com/ClaimsPaymentPolicies**. Enter Physician Admin in the keyword search and look for Physician Administered Drugs, effective 4/20/2021.

National Drug Code Billing Requirement — 2/25/2015

This Medicare Advantage and Medicaid policy establishes Humana's NDC billing requirement.

Please review the claims payment policy at **Humana.com/ClaimsPaymentPolicies**. Enter National Drug in the keyword search and look for National Drug Code Billing Requirement, effective 2/25/2015.

Multiple Evaluation and Management (E/M) services — 6/18/2024

This Kentucky Medicaid policy outlines Humana's billing requirements and reimbursement for multiple evaluation and management (E/M) services performed on the same day by the same provider.

Please review the claims payment policy at **Humana.com/ClaimsPaymentPolicies**. Enter EM Services in the keyword search and look for Multiple Evaluation and Management (E/M) services, effective 06/18/2024.

Long-Acting Reversible Contraception While Inpatient Postpartum — 7/11/2024

This Kentucky Medicaid policy outlines Humana's reimbursement for long-acting reversible contraception (LARC) provided to a postpartum inpatient.

Please review the claims payment policy at **Humana.com/ClaimsPaymentPolicies**. Enter LARC in the keyword search and look for Long-Acting Reversible Contraception While Inpatient Postpartum, effective 07/11/2024.

Claim submission requirements update — 12/1/2020

For billing, rendering, ordering, referring, prescribing and attending providers:

Effective Jan. 1, 2021, Humana Healthy Horizons™ in Kentucky will reject claims and encounters received electronically from clearinghouses that contain National Provider Identifiers (NPIs) not enrolled with the Kentucky Department for Medicaid Services (DMS). Rejected claims and encounters will not be accepted by the Humana Healthy Horizons in Kentucky claims platform and will not receive a Humana Healthy Horizons in Kentucky claim number. Please visit your clearinghouse's portal to review your rejected electronic claims.

Paper claims and encounters will be denied if the claim contains NPIs not enrolled with Kentucky DMS. Providers registered through Availity will be able to see claim denials on the Availity portal.

All claims submitted with dates of service on or after April 1, 2017, require that all listed NPIs related to

billing, rendering, ordering, referring, prescribing and attending providers be enrolled with Kentucky DMS.

Humana Healthy Horizons in Kentucky requires ordering and/or referring provider data for the following provider types:

Billing provider type	Billing provider type descriptions
18	Private duty nursing
36	Ambulatory surgery center
37	Independent lab
50	Hearing aid dealer
52	Optician
54	Pharmacy: all crossover services billed
70	Audiologist
76	Multi-therapy agency
79	Speech language pathologist
86	X-ray/miscellaneous supplier
87	Physical therapist
88	Occupational therapist
90	Durable medical equipment (DME)

If the data is missing, Humana Healthy Horizons in Kentucky will reject or deny the claim or encounter. Providers should submit claims in a manner that matches the data on the Kentucky DMS **Master Provider List (MPL)**. If the claim does not have the appropriate information, as required by Kentucky DMS, the claim will be denied. The following chart shows the information that providers must ensure is consistent with the information they include in their claims:

PROV TYPE	MEDICAID_BEGIN	MEDICAID_END	STATUS	LAST_NAME	NPI	NPI_EFFECTIVE_DATE	NPI_END_DATE	PRIM_ZIP	PRIM_ZIP_PLUS4	TAXONOMY
70	20180801	22991231	A	HAPPY HOSPITAL	1234567890	20070130	22991231	12345	123	222A00000X
36	20180801	22991231	A	HAPPIER HOSPITAL	1234567890	20070130	22991231	12345	456	222B00000X
80	20180801	22991231	A	HAPPIEST HOSPITAL	1234567890	20070130	22991231	12345	789	222C00000X

*The information in this chart is for illustration purposes only. It is only provided to demonstrate the fields providers must ensure are correct on their claims.

Please refer to the Kentucky DMS **Master Provider List (MPL)** to ensure your information is accurate.

For additional information on how to enroll with Kentucky DMS, please visit the Kentucky Cabinet for Health and Family Services' **New Enrollment, Revalidation or Maintenance page**.

For inpatient and psychiatric hospitals, psychiatric residential treatment facilities, nursing facilities, psychiatric distinct-part units and rehabilitation distinct-part units:

- Value code 80 must equal the total number of covered days as indicated on Form Locator 6
- The data entered in Form Locator 39 must agree with accommodation units on Form Locator 46

Please note: If the days covered are blank, non-numeric, equal zero, or there is a mismatch between units entered in Form Locator 39 and Form Locator 46, Humana Healthy Horizons in Kentucky will deny the claim.

If you have questions regarding this reminder, please contact Provider Services at 800-444-9137. Hours of operation are Monday through Friday, 7 a.m. to 7 p.m. Eastern time.

Kentucky Medicaid Regulation: 902 KAR 2:020 Reportable Disease Surveillance — 1/1/2021

The Cabinet for Health and Family Services (CHFS) released a Medicaid Administrative Regulation **902 KAR 2:020 Reportable Disease Surveillance** to their website.

This Regulation is effective December 15, 2020. The regulation establishes notification standards and specifies the diseases requiring immediate, urgent, priority, routine, or general notification, in order to facilitate rapid public health action to control diseases and to permit an accurate assessment of the health status of the Commonwealth.

The regulation covers the following information:

- Section 1: Definitions (page 1)
- Section 2: Notification Standards. (1) Health Professionals and Facilities (page 2)
- Section 3: Submission of Specimens to the Kentucky Department for Public Health Division of Laboratory Services (page 3)
- Section 4: Laboratory Testing and Submission of Specimens to the Division of Laboratory Services for the Identification of M. tuberculosis. (page 4)
- Section 5: Reporting Classifications and Methods (page 4)
- (1) Immediate Reporting
- (2) Urgent Reporting
- (3) Priority Reporting
- (4) Routine Reporting
- (5) General Reporting
- (6) Reporting Requirements
- Section 6: Notifiable Infectious Conditions Requiring Urgent Notification (page 6)
- Section 7: Notifiable Infectious Conditions and Notifiable Non-Infectious Conditions Requiring Priority Notification (page 7)

- Section 8: Notifiable Infectious Conditions and Notifiable Non-Infectious Conditions Requiring Routine Notification (page 8) Humana Healthy Horizons in Kentucky is a Medicaid product of Humana Health Plan Inc. 2
- Section 9: Notifiable Infectious Conditions Requiring Routine Notification by Electronic Laboratory Reporting (page 8)
- Section 10: Multi-Drug Resistant Organisms and Other Organisms Requiring Routine Notification by Electronic Laboratory Reporting (page 9)
- Section 11: Multi-Drug Resistant Organisms and Other Organisms Requiring Priority Reporting by EPID 250 and by Electronic Laboratory Reporting (page 9)
- Section 12: Newly Recognized Infectious Agents, HAI Outbreaks, Emerging Pathogens, and Pathogens of Public Health Importance (page 10)
- Section 13: Laboratory Surveillance (page 11)
- Section 14: Healthcare-Associated Infection Surveillance (page 11)
- Section 15: Antimicrobial Use Reporting (page 11)
- Section 16: Human Immunodeficiency Virus (HIV) and Immunodeficiency Syndrome (AIDS) Surveillance (page 12)
- Section 17: Sexually Transmitted Disease (STD) (page 13)
- Section 18: Tuberculosis (page 14)
- Section 19: Asbestosis, Coal Worker's Pneumoconiosis and Silicosis (page 14)
- Section 20: Reporting of Communicable Diseases in Animals (page 14)
- Section 21: Kentucky Public Health Advisory (page 15)
- Section 22: Penalty (page 15)
- Section 23: Incorporation by Reference (page 15)

If you have questions, please contact provider services at 800-444-9137. Hours of operation are Monday through Friday, 8 a.m. to 6 p.m. Eastern time

Annual sports physical exam — 7/6/2023

As children and teens receive their annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) well-child exam, please make sure to ask about and perform their annual sports physical exam during the same visit. While we know that there is significant overlap between the two types of exams, we want to ensure providers are credited for the work they do for our enrollees. Providers are recommended to bill for a sports physical in conjunction with a well-child exam for enrollees ages 6–18.

Humana Healthy Horizons® in Kentucky reimburses providers for one sports physical per year. After the value-added services (VAS) benefit limit (one visit per calendar year) is reached, no additional payments are made. Specific to sports physicals, providers are required to use the most appropriate Current Procedural Terminology (CPT®) code for services rendered along with the required ICD-10 code* of Z02.5.

Thank you for helping ensure pediatric members are safe to participate in the school sports, which can be a

critical part of their development, health and sense of belonging during their childhood and teen years. In addition, we thank you for educating parents on the importance of getting a full physical for their children and teens each year.

For questions, please email our Provider Relations staff at **KYMCDPR@humana.com** or call Provider Services at 800-444-9137, Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

* ICD-10 codes are from the International Classification of Diseases, 10th edition

Medicaid Physicians Certification Statement (PCS) Form for Non-Emergent Ground Transportation — 1/1/2024

Starting 1/1/2024, Humana Healthy Horizons in Kentucky will require submission of the Medicaid PCS Form along with supporting clinical documentation for ground non-emergent transportation services. This documentation is to be provided at the time of claims submission.

The Medicaid PCS form must be filled out in its entirety. For any section that is not applicable, fill in with N/A or Not Applicable. Incomplete submissions will result in claim denial.

The Medicaid PCS form can be found at https://assets.humana.com/is/content/humana/NEMT_Model_PCS_Formpdf.

If you have questions about this new requirement, please email our Provider Relations staff at KYMCDPR@humana.com or call Provider Services at 800-444-9137, Monday – Friday, 8 a.m. to 6 p.m., Eastern time

Cell and Gene Therapy (CGT) Access Model — 1/1/2026

Humana Healthy Horizons in Kentucky recently created a payment policy outlining its billing requirements and reimbursement for services rendered as part of the Centers for Medicare & Medicaid Services (CMS) Cell and Gene Therapy (CGT) Access Model.

Please review the new claims payment policy at **Humana.com/ClaimsPaymentPolicies**. Enter CGT in the keyword search and look for Cell and Gene Therapy (CGT) Access Model, effective 1/1/26.

Outpatient Drug Reimbursement Policy — 4/1/2026

Humana Healthy Horizons in Kentucky is updating its reimbursement methodology for outpatient drugs to align with the Kentucky Department for Medicaid Services, in accordance with 907 KAR 23.020. This adjustment ensures consistency with state Medicaid regulations regarding payment for outpatient prescription medications.

For further details, you may refer to the Kentucky Administrative Regulations: 907 KAR 23:020 - Kentucky Medicaid Outpatient Drug Reimbursement.

If you have questions about this notification, please call Provider Services at 800-444-9137, Monday - Friday, 8 a.m. - 6 p.m., Eastern time, or email Provider Relations at **KYMCDPR@humana.com**.

Intensive Outpatient Program Services claim payment policy — 4/1/2026

Humana Healthy Horizons in Kentucky shares this important information regarding Intensive Outpatient Program (IOP) services (HCPC H0015, S9480 and Revenue 0905) for providers treating our members.

According to the Kentucky Department for Medicaid Services (DMS), IOP services rendered to an adult must be provided for at least nine hours per week; the services must be provided for at least three hours per day and at least three days per week. Similarly, IOP services rendered to an adolescent must be provided for at least six hours per week; the services must be provided at least two days per week. IOP services must be provided by an applicable provider type in accordance to their governing regulations (which includes guidelines on, but not limited to: diagnosis specifications, providers who can render the service, components of IOP treatment, and limitations); be medically necessary; and follow the person centered plan of care. IOP services for Substance Use Disorder (SUD) treatment should also follow all of the current updates to ASAM levels of care and guidelines.

Humana requires a provider to bill a week of IOP services on the same claim. Providers are expected to report a week of IOP services using a rolling seven-day period. The first day of a covered service starts the 7-day period, rather than following a calendar week fixed Sunday through Saturday. Failure to submit the IOP claim consistent with this policy may result in a denial of the claim.

EXCEPTION:

Federally certified facility providers and Section 223 Waiver Demonstration for CCBHC providers billing services eligible for Kentucky's prospective payment systems rate (wrap payments) are exempt from this policy and must bill/report IOP services consistent with applicable guidance from DMS.

References:

1. Kentucky Administrative Regulations. Legislative Research Commission. **Title 907. Title 907 Kentucky Administrative Regulations • Legislative Research Commission**
2. Kentucky Administrative Regulations. Legislative Research Commission. **Title 907. Chapter 15 Regulation 080**
3. Kentucky Administrative Regulations. Legislative Research Commission. **Title 908. Chapter 1 Regulation 374 Section 4**
4. Kentucky Cabinet for Health and Family Services website. **Department for Medicaid Services. Humana Healthy Horizons in Kentucky website**
5. ASAM 2.1. **ASAM - American Society of Addiction Medicine**
6. 42 CFR 410.44. **https://www.ecfr.gov/current/title-42/section-410.44**

Behavioral Health Duplication of Services Policy — 4/1/2026

Humana Healthy Horizons in Kentucky shares this important information regarding duplicative services billed on the same date of service. Outpatient behavioral health services billed on a per diem basis are inclusive of most other behavioral health clinical services. In addition to awareness of the duplicative nature of the services below, providers should evaluate the medical necessity and clinical appropriateness of multiple services being delivered on a single date of service.

- Behavioral health per diem outpatient services are inclusive of clinical therapies as well as educational and supportive services as outlined in regulation.
  - Intensive outpatient treatment (H0015, S9480) shall include:
    - Individual outpatient therapy
    - Group outpatient therapy
    - Family outpatient therapy unless contraindicated

    - Crisis intervention
    - Psychoeducation, related to identified goals in the recipient's treatment plan
  - Partial hospitalization (H0035) shall include:
    - Individual outpatient therapy
    - Group outpatient therapy
    - Family outpatient therapy
    - Medication management
  - Therapeutic behavioral health services (H2020) shall include:
    - Improving daily living skills
    - Self-monitoring of symptoms and side effects
    - Emotional regulation skills
    - Crisis coping skills
    - Interpersonal skills
  - Day treatment (H2012) shall include:
    - Individual outpatient therapy, family outpatient therapy, or group outpatient therapy
    - Behavior management and social skills training
    - Independent living skills that correlate to the age and development stage of the recipient
    - Services designed to explore and link with community resources before discharge and to assist the recipient and family with transition to community services after discharge
  - Clinical BH services considered duplicative when billed on same date of service as above per diem services:
  - Assessments and screenings (H0001, H0002, H0031, H0032,90791, 96156)
    - According to regulation screenings "shall determine the likelihood that an individual has mental health disorder, substance use disorder or co- occurring disorder." Regulations also state assessments "shall establish or rule out the existence of a clinical disorder or service need." Accordingly, these services should be provided prior to delivering any of the BH per diem outpatient services.
  - Clinical therapies (90832, 90833, 90834, 90836, 90837, H0004, 90838, 90839,90840, 90846, 90847, 90849, 90853, 99406, 99407, 90887)
    - In addition to being explicitly listed in many of the service requirements for the BH per diem outpatient services, regulations mandate therapies shall "(n)ot exceed three hours per day alone or in combination with any other outpatient therapy per recipient unless additional time is medically necessary."
- Education and support services (H0025, H2015, H2019, H2020, H2027)
  - Withing the delivery of the BH per diem outpatient services, education, and support services should be provided to members as a component of the clinical delivery of that service.

As a reminder, Humana Healthy Horizons processes these claims for payment as indicated, per the provider's Humana Healthy Horizons contract agreement and/or the out-of-network payment policy

(https://assets.humana.com/is/content/humana/KY_PROV_Network_Notice_Humana_outof-network_claims_payment_policy_2023pdf.)

Once the enrollee exceeds the anticipated utilization established above, Humana Healthy Horizons may deny the claim. Providers may appeal the claim denial if they feel the service met criteria for medical necessity based on the individual member's clinical needs. The provider has 60 calendar days from the date of the original claim denial to file an appeal. Humana Healthy Horizons recommends providers specifically detailing "appeal" and submit medical records as supporting documentation to prove medical necessity for the service. For more information on appeals, please refer to the Kentucky Medicaid Provider Manual.

Additionally, claims paid for behavioral health services beyond the circumstances listed above may be reviewed for recovery.

If you have any further questions, please reach out to your provider relations representative, or call Provider Services at 800-444-9137, Monday through Friday, 8 a.m. – 6 p.m., Eastern time.

References:

1. **907 KAR 15:005. Definitions for 907 KAR Chapter 15.** Title 907 Chapter 15 Regulation 005 • Kentucky Administrative Regulations • Legislative Research Commission
2. **907 KAR 15:010. Coverage provisions and requirements regarding behavioral health services provided by individual approved behavioral health practitioners, behavioral health provider groups, and behavioral health multi-specialty groups.** Title 907 Chapter 15 Regulation 010 • Kentucky Administrative Regulations • Legislative Research Commission
3. **907 KAR 15:020. Coverage provisions and requirements regarding services provided by behavioral health services organizations for mental health treatment.** Title 907 Chapter 15 Regulation 020 • Kentucky Administrative Regulations • Legislative Research Commission
4. **907 KAR 15:022 Coverage provisions and requirements regarding services provided by behavioral health services organizations for substance use disorder treatment and co- occurring disorders.** Title 907 Chapter 15 Regulation 022 • Kentucky Administrative Regulations • Legislative Research Commission
5. **907 KAR 1:044 Coverage provisions and requirements regarding community mental health center behavioral health services.** Title 907 Chapter 1 Regulation 044 • Kentucky Administrative Regulations • Legislative Research Commission
6. 907 KAR 1:054 Coverage provisions and requirements regarding federally-qualified health center behavioral health services. Title 907 Chapter 1 Regulation 054 • Kentucky Administrative Regulations • Legislative Research Commission
7. 907 KAR 1:082 Coverage provisions and requirements regarding rural health clinic services. Title 907 Chapter 1 Regulation 082 • Kentucky Administrative Regulations • Legislative Research Commission

Incontinent Supply Reimbursement — 10/9/2025

Humana Healthy Horizons in Kentucky established claim reimbursement policies and procedures for incontinent home supplies that comply with Kentucky Department for Medicaid Services (DMS) regulations and contract requirements.

Currently, Kentucky DMS only provides coverage for the following provider types related to incontinent home supplies for adult Medicaid members:

- Home health agencies (34)
- Private duty nursing (18)

In addition, Medical Supplies, Equipment, and Appliance (MSEA) (90) provider types can dispense incontinent home supplies to children under the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) program only when deemed medically necessary.

Please refer to the regulatory references as published by Kentucky DMS:

- 907 KAR 1:479. Medical Supplies, Equipment, and Appliance covered benefits and reimbursement
- 907 KAR 1:030. Home health agency services
- 907 KAR 13:010. Private duty nursing service coverage provisions and requirements
- Kentucky DMS fee schedules
- EPSDT – Screenings – PT (45)

For questions, please contact Provider Services at 800-444-9137 (TTY: 711), Monday through Friday, 7 a.m. – 7 p.m., Eastern time.

Appeal Time Frame — 10/9/2025

Humana Healthy Horizons in Kentucky identified an omission in the Kentucky Provider Manual that requires clarification. Humana allows 60 calendar days from the date of the original medical necessity denial for a provider to appeal the determination. The appeals time frame is detailed in the medical necessity denial notice and provides instructions on how to submit the appeal. This is not a change in Humana's appeal process and has been in effect since Jan. 1, 2020.

Revisions to the Kentucky Medicaid Provider Handbook are in progress and include this clarification. Providers will be notified once the revised manual is posted online at **Humana.com/HealthyKY**. Because your participation agreement with Humana contains an obligation of compliance with provider manual provisions, it is important that all contracted plan physicians and administrators review the revised document once it is posted.

Vaccines for Children (VFC) billing modification — 8/11/2025

The Kentucky Department for Medicaid Services notified providers on Nov. 21, 2024, that beginning Jan. 1, 2025, Medicaid providers in Kentucky enrolled in the Vaccines for Children (VFC) program must use an "SL" modifier when billing Medicaid for the administration of VFC program vaccines. Providers must continue to bill an "SL" modifier on those procedure codes tied to the actual VFC vaccine code. Please see the changes referenced in federal regulation 42 C.F.R. 441.590.

As of Jan. 1, 2025, the expected VFC vaccine administration codes are 90460, 90471 and 90473. VFC vaccine administration code 90461 is longer billable or payable for Medicaid providers in Kentucky enrolled in the VFC program for vaccinations provided to VFC-eligible beneficiaries.

Peer Support Claims Covered Services Limitation Policy— 7/5/2025

Humana Healthy Horizons in Kentucky shares this important information regarding Peer Support Services, (CPT code H0038) for providers treating our members. Peer Support Services (PSS) are emotional supports provided as a supportive component of the members' individualized plan of care.

Key Characteristics of Peer Support Services

- Understanding the service requirements:
  - Services delivered must be based on evidence-based practices regarding frequency and volume of medically necessary services.
    - Humana Healthy Horizons limits Peer Support Services to 52 hours (208 units) per member, per provider group annually.
    - This approach is in alignment with limits set for Community Health Workers due to the similarity in goals of treatment and scope of providers.
  - Services should be clearly outlined within the individualized care plan, detailing the volume of services needed to promote socialization, recovery, self-advocacy, and skills needed for safe community living.
  - Peer Support when delivered in a group setting shall not exceed 8 members in a group; multiple groups may not be conducted at the same time.
- Provider requirements:
  - Individually enrolled providers are not reimbursed for PSS services, a group-level enrollment is required.
  - PSS services may be performed by a certified Peer Support Specialist (see regulations for details on the certification process) under appropriate supervision if necessary.
  - The same rendering provider cannot serve in a dual role when treating an individual member (e.g. Community Support Associates (CSA), Peer Support Specialists (PSS), Community Health Workers (CHW), etc).

As a reminder, Humana Healthy Horizons processes these claims for payment as indicated, per the provider's Humana Healthy Horizons contract agreement and/or the **out-of-network payment policy**.

Once the enrollee exceeds the anticipated utilization established above, Humana Healthy Horizons may deny the claim. Providers may appeal the claim denial if they feel the service met criteria for medical necessity based on the individual member's clinical needs. The provider has 60 calendar days from the date of the original claim denial to file an appeal. Humana Healthy Horizons recommends providers specifically detailing "appeal" and submit medical records as supporting documentation to prove medical necessity for the service. For more information on appeals, please refer to the **Kentucky Medicaid Provider Manual**.

Additionally, claims paid for Behavioral Health Policy Updates for Provider Education – Peer Support Services (H0038) beyond the circumstances listed above may be reviewed for recovery.

If you have any further questions, please reach out to your Provider Relations representative, or call Provider Services at **800-444-9137**, Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

References:

1. 907 KAR 15:005. Definitions for 907 KAR Chapter 15. Title 907 Chapter 15 Regulation 005 • Kentucky Administrative Regulations • Legislative Research Commission
2. 907 KAR 15:010. Coverage provisions and requirements regarding behavioral health services provided by individual approved behavioral health practitioners, behavioral health provider groups, and behavioral health multi-specialty groups. Title 907 Chapter 15 Regulation 010 • Kentucky Administrative Regulations • Legislative Research Commission

3. 907 KAR 15:020. Coverage provisions and requirements regarding services provided by behavioral health services organizations for mental health treatment. Title 907 Chapter 15 Regulation 020 • Kentucky Administrative Regulations • Legislative Research Commission
4. 907 KAR 15:022 Coverage provisions and requirements regarding services provided by behavioral health services organizations for substance use disorder treatment and co-occurring disorders. Title 907 Chapter 15 Regulation 022 • Kentucky Administrative Regulations • Legislative Research Commission
5. 907 KAR 1:044 Coverage provisions and requirements regarding community mental health center behavioral health services. Title 907 Chapter 1 Regulation 044 • Kentucky Administrative Regulations • Legislative Research Commission
6. 907 KAR 1:054 Coverage provisions and requirements regarding federally-qualified health center behavioral health services. Title 907 Chapter 1 Regulation 054 • Kentucky Administrative Regulations • Legislative Research Commission
7. 907 KAR 1:082 Coverage provisions and requirements regarding rural health clinic services 907
8. 908 KAR 2:200. Adult peer support Specialist. Title 908 Chapter 2 Regulation 220 • Kentucky Administrative Regulations • Legislative Research Commission
9. 908 KAR 2:230. Kentucky family peer support specialist. Title 908 Chapter 2 Regulation 230 • Kentucky Administrative Regulations • Legislative Research Commission
10. 908 KAR 2:240 Kentucky youth peer support specialist. Title 908 Chapter 2 Regulation 240 • Kentucky Administrative Regulations • Legislative Research Commission
11. KRS 309.0831 Requirements for registration as an alcohol and drug peer support specialist. statute.aspx
12. Kentucky Department for Public Health CHW Medicaid Billing Best Practice Guide for Local Health Departments LHD CHW Billing Guide_Final_2025.pdf

Psychoeducation Claims covered Service Limitation Policy — 7/5/2025

Humana Healthy Horizons in Kentucky shares this important information regarding Psychoeducation services, (CPT code H2027) for providers treating our members. Psychoeducation is a structured intervention presented by a qualified and licensed physician or behavioral health clinician. It aims to educate individuals diagnosed with psychiatric, substance use, or co-occurring disorders, along with their families, about the identified condition and treatment options.

Key Characteristics of Psychoeducation

- Delivery Method:
  - Offered to individuals or individuals and their families
  - In support of and as an adjunct to clinical treatment
- Goals:
  - Designed to prevent relapse or the development of comorbid disorders
  - Aims for optimal health and long-term resilience
- Treatment Support:
  - Acts as a component of the treatment process
  - Helps individuals and families understand:
    - The individual's diagnosis and symptoms

- Causes of the condition and its impact on development
- Components of treatment and the benefits of various options
- Skills development to cope with the diagnosis

Current Evidence and Utilization

- Literature Review: A review indicates a lack of evidence supporting psychoeducation as standard medical treatment. There are no widely used treatment guidelines or clinical literature establishing its value in clinical management for these indications.
- In most instances, psychoeducation is a component service within other clinical services and will not be reimbursed separately. For example, psychoeducation is a component of day treatment, therapeutic rehabilitation program (TRP), intensive outpatient program (IOP), partial hospitalization program (PHP), and residential services. Because it is included in the per diem rate for those services it cannot be billed separately on the same day.
- Utilization expectations: Humana Healthy Horizons recognizes psychoeducation as a short- term clinical tool for treating behavioral health conditions may be needed as a stand-alone service under some circumstances. Utilization of this education-like intervention as a stand- alone service above 20 units (H2027; 15-minute service unit) annually is not supported based on the current definition and lack of standard treatment guidelines or clinical evidence.

As a reminder, Humana Healthy Horizons processes these claims for payment as indicated, per the provider's Humana Healthy Horizons contract agreement and/or the **out-of-network policy**.

Once the enrollee exceeds the anticipated utilization established above, Humana Healthy Horizons may deny the claim. Providers may appeal the claim denial if they feel the service met criteria for medical necessity based on the individual member's clinical needs. The provider has 60 calendar days from the date of the original claim denial to file an appeal. Humana Healthy Horizons recommends providers specifically detailing "appeal" and submit medical records as supporting documentation to prove medical necessity for the service. For more information on appeals, please refer to the **Kentucky Medicaid Provider Manual**.

Additionally, claims paid for Behavioral Health Policy Updates for Psychoeducation (H2027) beyond the circumstances listed above may be reviewed for recovery.

If you have any further questions, please reach out to your Provider Relations representative, or call Provider Services at **800-444-9137**, Monday – Friday, 8 a.m. – 6 p.m. Eastern time.

References:

1. Agency for Healthcare Research and Quality (AHRQ). Comparative Effectiveness Review Evidence Summary (ARCHIVED). Treatments for schizophrenia in adults: a systematic review. https://www.ahrq.gov. Published October 2017.
2. American Academy of Child and Adolescent Psychiatry (AACAP). Clinical practice guideline for the treatment of children and adolescents with major and persistent depressive disorders. https://www.aacap.org. Published May 2023.
3. American Academy of Child and Adolescent Psychiatry (AACAP). Practice parameter for the assessment and treatment of children and adolescents with schizophrenia. https://www.aacap.org. Published September 2013.
4. American Psychiatric Association (APA). Practice guideline for the treatment of patients with

schizophrenia. https://www.psychiatry.org. Published September 1, 2020.

5. Hayes, Inc. Medical Technology Directory. Psychosocial interventions as adjunct treatments for pediatric bipolar disorder. https://evidence.hayesinc.com. Published October 12, 2010. Updated October 15, 2014.
6. Lyman DR, Braude L, George P et al. Consumer and family psychoeducation: assessing the evidence. Psychiatr Serv. 2014;65(4):416-28. Psychoeducation
7. Magill M, Martino S, Wampold B. The principles and practices of psychoeducation with alcohol or other drug use disorders: a review and brief guide. J Subst Abuse Treat. 2021;126:108442.
8. UpToDate, Inc. Bipolar disorder in adults: psychoeducation and other adjunctive maintenance therapies. https://www.uptodate.com. Published October 2024.
9. UpToDate, Inc. Geriatric bipolar disorder: general principles of treatment. https://www.uptodate.com. Published October 2024.
10. UpToDate, Inc. Pediatric bipolar disorder: efficacy and core elements of adjunctive psychotherapy. https://www.uptodate.com. Published October 2024.
11. UpToDate, Inc. Psychosocial interventions for schizophrenia in children and adolescents. https://www.uptodate.com. Published October 2024.
12. 12. UpToDate, Inc. Psychotherapy for anxiety disorders in children and adolescents. https://www.uptodate.com. Published October 2024.
13. 13. UpToDate, Inc. Schizophrenia in adults: psychosocial management. https://www.uptodate.com. Published October 2024.
14. 14. UpToDate, Inc. Specific phobias in adults: cognitive behavioral therapy. https://www.uptodate.com. Published October 2024.
15. 15. UpToDate, Inc. Unipolar depression in adults: family and couples therapy. https://www.uptodate.com. Published October 2024

Senate Bill 111 Treatment of Stuttering — 1/1/2025

Effective Jan. 1, 2025, and in compliance with Kentucky Senate Bill 111 **CHAPTER 69 (SB 111, Westerfield and Thomas)**, prior authorization will not be required for any service that is requested for the treatment of stuttering. To ensure proper adjudication of stuttering treatment services, providers should bill with one of the following diagnoses codes* as defined on the applicable claim form for a primary diagnosis in positions 1 through 5.

F80.81 Childhood onset fluency disorder F98.5 Adult onset fluency disorder

R47.82 Fluency disorder in conditions classified elsewhere I69.323 Fluency disorder (stuttering) following cerebral infarction

I69.923 Fluency disorder (stuttering) following unspecified cerebrovascular disease

In addition, the treatment of stuttering will not be subject to a maximum annual limit.

Medicaid Provider External Independent Review (EIR) Intake Form — 10/1/2024

Humana Healthy Horizons in Kentucky has partnered with the Kentucky Department for Medicaid Services to create an EIR Intake Form. Providers will be required to use this form and submit to the

MCO to request an EIR effective October 1, 2024.

The form can be found at: **https://assets.humana.com/is/content/humana/KY_External_Independent_Review_Request_Formpdf**

Using the form:

- Please use this form for all EIR requests. Verbal EIR requests will not be considered.
- Written requests not on this form will not be considered.
- If you would like to submit an EIR request, please use this form after you have exhausted the MCO's internal appeal process.
- An EIR must be submitted within 60 calendar days of the MCO final adverse determination. The 60-calendar day timeline begins with one of the following:
  - Date that the notice was received electronically, if received electronically.
  - Date that the notice was received via fax, per the date and time documented on the fax transmission, if the notice was faxed; or

  Postmark date on the envelope containing the notice, if the notice was sent via postal mail. An additional 3 days shall be added if the service is by mail.
  - Please do not use the claim 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.
- Please 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, please provide a specific explanation of its contents.
- Please 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: Meaning cases stemming from the dollar amount paid on a claim or denial of a claim.
- Medical necessity adverse benefit determination: Meaning a case stemming from an adverse medical necessity determination.

Types of cases not eligible for EIR:

The following submissions will not be considered.

- Cases where the form is not filled out in its entirety
  - Please note incomplete forms may be resubmitted within the timely filing period.
- Cases where MCO internal appeal rights have not been exhausted
- Cases where the timely filing period has passed.
- Claims that are part of a 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.

If you have any further questions, please reach out to your Provider Relations representative, or call Provider Services at **800-444-9137**, Monday through Friday, 8 a.m. – 6 p.m., Eastern time.

Expanded retrospective review — 8/1/2024

Effective immediately, Humana Healthy Horizons in Kentucky expands its retrospective review policy to allow for both retrospective enrollee eligibility and provider enrollment time frames.

Definition

A retrospective review is a request for a review for authorization of care, service or benefit for which authorization is required but not obtained before the delivery of care, service or benefit. Humana Healthy Horizons requires prior authorization to ensure covered patients receive medically necessary and appropriate services. **Authorization requests that do not meet the necessary criteria as described below are administratively denied**. Claims filed for services that require authorization also deny if not authorized.

Retrospective review policy

Humana Healthy Horizons only performs retrospective authorization reviews after a provider request through standard authorization request processes in the following circumstances:

Requests for retrospective review that exceed the time frames and do not meet the criteria outlined above are denied.

What to include when submitting a retrospective review request

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

Cause for review	Request time frame requirements
Enrollee was not enrolled with Humana Healthy Horizons on the date of service, but enrollee was retroactively assigned coverage for the date of service through Medicaid enrollment processes.	**Within 12 months from** the date eligibility was updated with Kentucky Department for Medicaid Services.
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** • 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.	

How to submit a retrospective review request

Providers can submit a retrospective review request for inpatient and outpatient services via:

- Availity Essentials™ at **Availity.com** (registration required)
- Phone/interactive voice response: **800-444-9137** (TTY: 711), Monday through Friday, 8 a.m. – 6 p.m., Eastern time
- Fax: **833-974-0059**

Providers can view authorization status, along with the authorization number associated with the request at **Availity.com**. Some outpatient authorization requests may auto-approve even when the procedure code may not appear on our preauthorization list (PAL). The Humana Healthy Horizons PAL is available online at **Humana.com/PAL**. Approved service requests are available on Availity.com. Providers may request written notification when submitting clinical information or by calling **800-444-9137**, Monday through Friday, 8 a.m. to 6 p.m., Eastern time.

If you have any questions about this update to the retrospective review request process, please call Provider Services at **800-444-9137**, Monday through Friday, 8 a.m. to 6 p.m., Eastern time.

Modifier 52 & 53 billing — 3/1/2024

Humana Healthy Horizons in Kentucky recently updated its payment policy regarding two procedure code modifiers.

Modifier 52

Use **modifier 52** if the procedure is partially reduced or if the procedure is discontinued either before anesthesia is administered or if anesthesia is not planned. Humana allows 50% of the contracted rate or the base maximum amount payable under the enrollee's plan when modifier 52 is appropriately appended to a procedure code.

Modifier 52 is not an appropriate modifier for an evaluation and management (E/M) code or a laboratory panel code. If modifier 52 is used with an E/M or a laboratory panel code, Humana rejects or denies the claim.

In addition to the policy, payments are subject to other plan requirements for processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements.

Modifier 53

Humana requires providers to report **modifier 53** if the procedure is discontinued after anesthesia is administered.

Modifier 53 should not be used for:

- E/M codes
- Facility claims
- Charges for laparoscopic and endoscopic procedures converted to open procedures

Humana rejects or denies a charge if modifier 53 is submitted inappropriately.

When modifier 53 is appropriately appended to a service code, Humana allows:

- 29% of the provider's contracted rate; **or**

- 29% of the base maximum amount payable under the enrollee's plan (when the provider is not contracted)

Please note: In certain circumstances, additional payment rules may apply. For example (and when applicable), claims are subject to the Humana Healthy Horizons in Kentucky out-of-network payment policy. For more information, see the relevant guidance in the **references** section of this policy.

Modifier 78 billing — 3/1/2024

Humana Healthy Horizons in Kentucky recently updated its payment policy regarding **modifier 78**.

Humana allows a return trip to the operating or procedure room, as indicated by the use of modifier 78, at 70% of the practitioner's contracted rate or base maximum amount payable under the enrollee's plan for the service.

This policy applies only to charges for practitioner services for procedure codes identified in the Medicare Physician Fee Schedule (MPFS) Relative Value file with global surgery periods.

Please note: In certain circumstances, additional payment rules may apply. For example (and when applicable), claims are subject to the Humana Healthy Horizons in Kentucky out-of-network payment policy. For more information, see the relevant guidance in the **references** section of this policy.

In addition to the policy, claims payments are subject to other plan requirements for processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements.

Ambulatory surgical center (ASC) bundled services — 3/1/2024

Humana Healthy Horizons wants to remind providers of the following claims payment guideline relating to ambulatory surgical center (ASC) bundled services.

For ASC services, Kentucky Medicaid requires that procedure codes considered a packaged service by Centers for Medicare & Medicaid Services with a Medicare rate of $0 are not reimbursed.

Medicaid-covered procedures not included on the Medicare fee schedule are reimbursed at 45% of billed charges. For more information, please reference section 2 of 907 KAR 1:008 and "Ambulatory Surgical Center Services and Reimbursement," found at **https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx**.

Medicaid-covered procedures included on the Medicare fee schedule without a rate will also be reimbursed at 45% of billed charges.

Medical Supplies, Equipment, and Appliance Rental (MSEA) — 3/1/2024

Humana Healthy Horizons wants to remind our medical supplies, equipment, and appliance (MSEA) suppliers of claims payment guidelines relating to the rental of MSEA.

If reimbursement for a rental item is made for a period of 10 consecutive months, or the total rental reimbursement exceeds the purchase price, the item is then considered purchased and becomes the property of the recipient. Claims submitted after the tenth month of rental, or when the total cost of rental payments surpasses the purchase price, may be subject to denial.

For more information regarding this guideline, please reference Section 8 of 907 KAR 1:479, Reimbursement for Covered Services at **https://apps.legislature.ky.gov/law/kar/titles/907/001/479/**.

Venipunctures, evaluation and management (EM) services — 3/1/2024

Humana Healthy Horizons wants to remind providers of claims payment guidelines relating to the billing of venipunctures and evaluation and management services.

Billing charges for a laboratory test performed by a dipstick, reagent strip or tablet in a provider's office are included in the office visit charge. Charges for routine venipuncture are not separately reimbursable if submitted with an evaluation and management service. For more information, please refer to Section 6 of 907 KAR 3:010 by visiting **https://apps.legislature.ky.gov/law/kar/titles/907/003/010/**.

Evaluation and management services are allowed once per member, per provider, per date of service. If the service is a significant, separately identifiable evaluation and management service provided by the same provider to the same patient on the same day of the procedure, the appropriate modifier must be billed as outlined in the billing instruction manual. Claims may

be subject to denial if not appropriately billed per Kentucky DMS billing guidelines at

https://www.kymmis.com/kymmis/provider%20relations/billingInst.aspx.

Vitamin D testing — 1/1/2024

Coverage

Humana Healthy Horizons enrollees may be eligible for vitamin D testing for the following indications:

- Diagnosis code 1 associated with vitamin D deficiency reported on the claim, reflecting a need for monitoring
- Established or suspected vitamin D toxicity, as evidenced by one or more of the following:
  - Hypercalcemia
  - Hypercalciuria
  - Sarcoidosis
- Evidence of repeat testing for an individual with a previously documented vitamin D deficiency of at least 3 months after initiation of vitamin D supplementation to monitor progress towards a therapeutic goal (serum concentration between 20 and 40 ng/mL)

Limitations

Humana Healthy Horizons enrollees are not eligible for vitamin D testing for general population screening or any indications other than those listed previously. This is considered experimental/investigational as it is not identified as widely used and generally accepted for any other proposed use, as reported in nationally recognized peer-reviewed medical literature published in the English language.

Humana Healthy Horizons enrollees are not eligible for vitamin D testing utilizing more than one Current Procedural Terminology (CPT®) code in any combination. This is considered experimental/investigational as it is not identified as widely used and generally accepted for the proposed use as reported in nationally recognized peer-reviewed medical literature published in the English language.

Humana Healthy Horizons enrollees are not eligible for vitamin D testing more frequently than twice in a rolling 12-month period* for any covered diagnosis other than chronic kidney disease, end-stage renal disease or intestinal malabsorption. This is considered experimental/investigational as it is not identified as widely used and generally accepted for the proposed use as reported in nationally recognized peer- reviewed medical literature published in the English language.

Humana Healthy Horizons enrollees are not eligible for vitamin D testing to monitor supplementation therapy more frequently than twice in a rolling 12-month period*. This is considered experimental/ investigational as it is not identified as widely used and generally accepted for the proposed use as reported in nationally recognized peer-reviewed medical literature published in the English language.

* A rolling 12-month period is 12 months after an event, regardless of what month the initial event took place (e.g., initial vitamin D test performed July 1, 2023, the rolling 12-month period would end June 30, 2024).

Resources (Subject to change per source)

1. **A56798– Expected Dx codes for Vitamin D Testing (LCDs)**
2. **National Institute of Health**
3. **National Library of Medicine**
4. **US Preventive Services Task Force (USPSTF)**
5. **CMS Expected Diagnosis codes for Vitamin D Testing – CMS LCD A57718**

Viral hepatitis serology — 1/1/2024

Coverage

Humana Healthy Horizons enrollees may be eligible for viral hepatitis serology testing when the billed diagnosis code(s) indicate:

- Liver disease
- Liver abnormalities
- Testing for the above indications during pregnancy or infertility treatment

Limitations

Viral hepatitis serology testing coverage is limited to the coverage requirements noted previously. Appropriate and expected CPT codes and ICD-10 diagnosis codes are documented by CMS and the American Medical Association (AMA) as noted below.

Resources

1. **CMS National Coverage Determinations (NCD) – Hepatitis Panel/Acute Hepatitis Panel**
2. **National Library of Medicine**
3. **CMS Healthcare Common Procedure Coding System, HCPCS Release and Code Sets**
4. **AMA Current Procedural Terminology (CPT®) Professional Edition and associated publications and services**
5. **Cabinet for Health and Family Services**

Sexually transmitted infection testing — 1/1/2024

Coverage

Humana Healthy Horizons enrollees are eligible for sexually transmitted infection testing, for both men and women, as billed under 87491, 87591 and 87661. Procedure code 87801 reflects

comprehensive testing, as it is billed when more than one test is performed for the same enrollee on the same date of service and in the same billing group. Humana Healthy Horizons covers one unit with the billing code 87801, regardless of the units that would be billed for the single test.

Limitations

Billed services eligible for coverage are limited to 87491, 87591, 87661 and 87801, as billed on a professional claim (CMS-1500 or 837P) or institutional claim (UB-04 or 837I) form. Procedures rendered are covered when performed for the detection of gonorrhea, chlamydia or trichomonas vaginalis.

Resources

1. **Centers for Disease Control and Prevention (CDC)**
2. **CMS Manual – Pub. 100-3 National Coverage Determination / 210.10 – Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to Prevent STIs**
3. **AMA Current Procedural Terminology (CPT®) Professional Edition and associated publications and services**
4. **Cabinet for Health and Family Services**

Laboratory tests with or without comprehensive tests — 1/1/2024

Coverage

Humana Healthy Horizons enrollees are eligible for a single laboratory test when billed on its own without additional laboratory tests for the same enrollee with the same date of service through the same billing provider. Comprehensive laboratory testing is billed when more than one laboratory test is performed for the same enrollee on the same date of service and by the same billing provider.

Limitations

Single laboratory tests billed that are found in group 8 (as indicated by CMS2) are not considered covered as they should be billed under the comprehensive laboratory testing benefit for the same enrollee on the same date of service and by same billing provider. A single laboratory test billed in conjunction with a comprehensive laboratory test is not expected and will not be covered without additional clinical information for the diagnosis(s) supporting the need through a records review.

Resources

1. **CMS Billing and Coding guidelines, LCD A58761**
2. **CMS Billing and Coding: Frequency of Lab Tests (A56420)**

Fee schedule — 8/14/2023

Humana Healthy Horizons in Kentucky announces a procedural change specific to the adoption of the Kentucky Department for Medicaid Services (Kentucky DMS) fee schedules for existing published codes and modifiers. This update impacts the following provider types:

- Advanced registered nurse practitioner (ARNP) – 78, 789
- Ambulatory surgical centers – 36
- Audiologist – 70, 709
- Behavioral health multi-specialty group – 66
- Behavioral health services organization – 03
- Birthing centers – 73
- Certified registered nurse anesthetist (CRNA) – 74, 749
- Chiropractor – 85, 859
- Community mental health centers – 30
- Comprehensive outpatient rehabilitation facilities – 91
- Dentist – 60, 61
- Early Periodic Screening Diagnosis and Treatment (EPSDT) services: Screenings – 45
- EPSDT services: Special services – 45
- Emergency transportation – 55
- Family planning services – 32
- Federally qualified health center (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
- Non-emergency transportation – 56
- Nursing facility – 12
- Occupational therapist – 88, 889
- Optician – 52, 529
- Optometrist – 77, 779
- Physical therapist – 87, 879
- Physician assistant – 95, 859
- Physician services – 64, 65
- Podiatry services – 80, 809
- Primary care – 31
- Private duty nursing – 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

Beginning August 14, 2023, Humana Healthy Horizons will not adjust previously paid claims in accordance with retroactive fee schedule modifications issued by Kentucky DMS for existing published codes and modifiers. Except in cases of overturned appeals or disputes, all claim payments are considered in full and final to the fee schedule issued by the Kentucky DMS as it is configured in Humana's systems on the date of claim(s) payment. We will publish updates to our existing fee schedules on **Humana.com/KYFeeSchedules** on an ongoing basis, providing the effective date of the systems configuration. For example:

- A published PDF of the Kentucky DMS fee schedule titled and including the effective date Kentucky DMS ASC fee schedule, effective XX/XX/XXXX
- A published PDF of the Kentucky DMS fee schedule titled and including the effective date Kentucky DMS Audiology fee schedule, effective XX/XX/XXXX

This policy does not include new codes added in fee schedule updates published by Kentucky DMS. In those instances when Kentucky DMS adds a new code or modifier, Humana will adjust previously adjudicated claims impacted by such a modification in accordance with all applicable retroactive effective date(s).

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

Emergency department E/M reimbursement — 7/23/2023

Humana Healthy Horizons in Kentucky's payment policy for emergency department evaluation and management (E/M) claim reimbursement, effective Jan. 1, 2023, was recently updated. The policy communicates the criteria used to determine the level of reimbursement for facility E/M services provided in the emergency department.

When the criteria associated with the facility's billed emergency department E/M service code are not satisfied, Humana reimburses at the emergency department E/M service code only at the level for which the criteria in the emergency department E/M reimbursement policy linked below are met. Humana does not reimburse at a higher E/M service code than billed.

The updates noted in the policy will become effective for dates of admission on or after July 1, 2023.

Please review the new claims payment policy at **Humana.com/ClaimsPaymentPolicies**. Enter Emergency Department E/M Reimbursement in the keyword search and look for "Emergency Department E/M Reimbursement (Revised)."

Neonatal Intensive Care Unit (NICU) Claims Payment — 7/11/2025

Humana Healthy Horizons in Kentucky recently updated its payment policy for diagnosis-related group (DRG) claim reimbursement for Neonatal Intensive Care Unit (NICU) services.

For a claim with a discharge date on or after May 29, 2025, Humana reviews additional factors to calculate reimbursement of the DRG outlier payment, when applicable, according to CMS MS-DRG guidelines. This includes reviewing whether the provider has billed for any days that do not meet medical necessity requirements. It also includes reviewing the following data on the claim:

- The level of care as reported by the NICU revenue code, according to the applicable criteria established by MCG Health;
- The number of days billed; and

- The dates of service.

Please review the new claims payment policy at **Humana.com/ClaimsPaymentPolicies**. Enter "NICU" in the keyword search and look for "Neonatal Intensive Care Unit (NICU) Guidelines (Revised)".

Bypass for Medicare Codes — 5/1/2023

Medicaid services not covered under Medicare

Providers are able to bill Humana Healthy Horizons in Kentucky directly without the requirement to provide an explanation of benefits or Medicare primary payer information on the claim when the services are not covered by Medicare. Providers are encouraged to work with Kentucky DMS on proposed additions to their Medicare bypass guidelines. All updates made will be implemented and in effect 90 days from our receipt of notice from Kentucky DMS.

Humana Healthy Horizons does not adjust previously paid claims in accordance with retroactive fee schedule modifications issued by Kentucky DMS, as documented on our website at **https://www.humana.com/provider/medical-resources/kentucky-medicaid/fee-schedules**. Medicare bypass requirements can be specific to provider type, claim type, procedure, revenue, diagnosis codes, and/or date range. As Medicare does not cover these codes, Medicaid acts as primary payer without the need for proof of Medicare claim processing. Claims that do not meet all bypass requirements are denied when submitted to Humana Healthy Horizons without an explanation of Medicare benefits, which is required for appropriate coordination of benefits.

Bypass for Commercial Codes — 5/1/2023

Background:

The six Kentucky Medicaid Managed Care Organization (MCOs), worked to develop a centralized commercial insurance coding list for those specific procedure codes and modifiers typically deemed as not covered outside of Medicaid. This list allows providers to bill the KY Medicaid MCO for Primary coverage without the need to provide evidence of Commercial coverage on their claims. Kentucky healthcare providers must still bill the primary carrier as Kentucky Medicaid is the payer of last resort.

The referenced list will be available on each of the respective Kentucky Medicaid MCOs provider web portals. As a reminder, the process allows providers to bill directly to the Kentucky Medicaid MCO without submitting an Explanation of Benefits (EOB) if only procedure codes or modifiers on the list are on the claim submitted. Otherwise, an EOB is still required.

Attestation Form:

If an EOB cannot be obtained from the commercial payer, then a centralized attestation form can be attached to the claim. The attestation form must be complete, legible, and applicable to the right member and provider in order to be considered valid and accepted by the Kentucky Medicaid MCOs for primary insurance processing. This form can be found on the MCO's provider web portal.

Effective:

This process is effective for dates of service beginning May 1st, 2023, and subject to change

with advance notice. This commercial coding process does not apply to any dates of service prior to May 1st, 2023.

Provider Action Needed:

Claims must adhere to the Kentucky Department for Medicaid Services (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 or attestation form for appropriate coordination of benefits.

Attestation Form link: https://assets.humana.com/is/content/humana/KY_MCD_Attestation_Templatepdf

SUD 1115 Waiver billing requirements — 11/1/2022

Humana Healthy Horizons in Kentucky covers enrollee short-term stays for residential substance-use disorder (SUD) treatment, according to Kentucky Department for Medicaid Services (Kentucky DMS) policies and the current SUD 1115 Waiver. Specific billing requirements related to SUD residential treatment claims are detailed below:

Billing requirements related to SUD Residential Treatment:

- The service address MUST be present on the claim. On a CMS-1500 form, this information should appear in either field 32 or 33.
- Claim information, such as taxonomy, National Provider Identifier (NPI), Tax ID, etc., must match the provider type permitted to deliver the service:
  - Behavioral Health Service Organization (BHSO)—PT03, Tier 3
  - Chemical Dependency Treatment Center (CDTC)—PT06
  - Residential Crisis Stabilization Unit (RCSU)—PT26
  - Community Mental Health Center (CMHC)—PT30
- "Place of Service" code should be accurate and allowable for the enrolled provider type.
- The service location, when billing American Society of Addiction Medicine (ASAM) Levels of Care (enhanced codes), must be:
  - Approved by Kentucky DMS through the SUD 1115 Waiver attestation process and included on the Kentucky DMS weekly SUD provider file, or
  - Detailed on the Commission on Accreditation of Rehabilitation Facilities (CARF) ASAM Certification document, including service location and ASAM level of care

For more information, please refer to Provider Billing Instruction Manuals published by the Kentucky Cabinet for Health and Family Services by Provider Type, found online at KYHealth-Net (**kymmis.com**).

CARF ASAM Certification:

Providers who applied and received certification must notify Human healthy Horizons in Kentucky to ensure accurate claims payment. Please email a copy of the certification to **KYBHMedicaid@humana.com** and include "CARF ASAM Certification" in the subject line. Humana Healthy Horizons in Kentucky requests notification within five business days of receiving the certification.

Substance Use Disorder Residential Treatment services are subject to prior authorization. The following are exceptions to this requirement:

- Emergent services
- Kentucky DMS COVID-19 prior authorization requirement exclusions

Humana Healthy Horizons reserves the right to initiate overpayment recovery of claims identifies

as overpaid, pursuant to Kentucky DMS reimbursement guidelines and its Medicaid Managed Care Contract.

Anesthesia modifier billing — 7/1/2022

Humana Healthy Horizons in Kentucky and the Kentucky Department for Medicaid Services (DMS) issued an email advising that, effective July 1, 2022, all fee-for-service anesthesia claims require the use of selected anesthesiologist and Certified Registered Nurse Anesthetist (CRNA) modifiers. Fee- for-service billing instructions were updated per the effective date.

Effective July 1, 2022, all fee-for-service anesthesia claims require the use of one of the following modifiers:

- **Anesthesiologist modifiers:**
  - AA—Anesthesiologist providing anesthesia procedure; Rate: 100% of rate listed on physician fee schedule
  - QY—Anesthesiologist providing medical direction for anesthesia procedure by 1 CRNA; Rate: 50% of rate listed on physician fee schedule
  - QK—Anesthesiologist providing medical direction for anesthesia procedure to 2, 3 or 4 concurrent CRNAs; Rate: 50% of rate listed on physician fee schedule
  - AD—Anesthesiologist providing medical direction for anesthesia procedure to more than 4 concurrent CRNAs; Rate: 50% of rate listed on physician fee schedule
- **CRNA modifiers:**
  - QZ—CRNA providing anesthesia procedure with no medical direction; Rate: 75% of rate listed on physician fee schedule
  - QX—CRNA providing anesthesia service with medical direction; Rate: 50% of rate listed on physician fee schedule

Codes covered: 00100 through 01999, plus 99100

Effective date of regulation (KY Medicaid coverage of Medical Direction for Anesthesia, per 907 KAR 3:010, Sect 8.): Oct. 20, 2021.

Required forms: notice completion, retention and claim submission

Humana Healthy Horizons™ in Kentucky and the Kentucky Department for Medicaid Services (DMS) require the completion of a specific form(s) for the following services:

- Abortion
- Early elective delivery
- Hysterectomy
- Hospice
- Sterilization

Refer to the Kentucky Department for Medicaid Services references and forms section of this notice to review the required forms.

As the provider, you are required to:

• Complete the required documentation according to the appropriate Kentucky Administrative Regulation and/or Kentucky DMS Memorandum.

• Retain the completed form(s) or documentation as part of the member's chart in the event of an audit. Submit a copy to Kentucky DMS upon request.

Claim Submission Requirements:
Submit the following required documentation with the claim for the specified service to validate medical necessity to meet Medicaid coverage requirements:

- Abortion:
  - Pre-op and/or post-op notes,
  - the abortion certification and requirements form, and
  - the report of abortion form
- Sterilization:
  - Sterilization OBM Consent for Sterilization
- Early elective delivery:
  - Either the ACOG Patient Safety Checklist Induction of Labor OR pertinent medical records.
  - Prior authorization is **not** required. Forms and medical records should **not** be submitted through the prior authorization process. Doing so may result in a claim denial. To ensure timely processing, required form(s) and/or medical records must be submitted with the claim.
- Hysterectomy: Hysterectomy Consent Form Map 251

Please note: Claims for these services must also include the Coordination of Benefit, as appropriate. Please refer to **Documents and Resources for Kentucky Medicaid - Humana** for resources related to claims submission, grievance and appeals.

Claims are denied when the provider submits without the completed form(s) and/or medical records as required. If Humana Healthy Horizons in Kentucky erroneously pays a claim without the required form(s) and/or medical records, Humana Healthy Horizons in Kentucky may initiate overpayment recovery efforts per regulatory and contractual requirements.

Kentucky Department for Medicaid Services references and forms:
Abortion:

- **VS_913_04.2020_Report of Abortion**
- **CHFS_ACR_2.2020_Abortion Certification Requirements**
- **Certification Form for Induced Abortion or Induced Miscarriage**

Sterilization:

- **Consent for Sterilization: Form HHS-687**

Early elective deliveries:

- **Early elective Deliveries (EED) Prior to 39 weeks Gestation_06232017**
- **Addendum to 06232017 EED Prior to 39 Weeks Gestation**
- **ACOG Patient Safety Checklist Induction of Labor**

Hysterectomy:

- **Map251_Hysterectomy Consent Form**

Hospice Medicaid Benefit election:

- **Map374_Election of medicaid Hospice Benefit**

You also can find the Kentucky Cabinet for Health and Family Services (CHFS) forms on our **Humana Healthy Horizons in Kentucky Provider Documents & Resources page**.

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

Medical Supplies, Equipment, and Appliance (MSEA) Claims Payment — 1/21/2021

Effective June 21, 2021, Humana Healthy Horizons in Kentucky no longer accepts claims with a "NU" modifier for MSEA . Please use the "RR" equipment rental modifier in the appropriate field. This change is to align with Kentucky Department for Medicaid Services provider billing instructions for MSEA.

For more information, please visit **http://www.kymmis.com/kymmis/pdf/billingInstr/PT90withMedicare_v6.5_%2801-10-2022%29.pdf**

Urine drug testing — 7/1/2020

On July 1, 2020, Humana Healthy Horizons implemented the Kentucky Department for Medicaid Services' **updated urine drug testing (UDT) policy**. As a reminder, Humana Healthy Horizons now processes these claims for payment as indicated by the department's policy, per the provider's Humana Healthy Horizons contract agreement and/or the out-of-network payment policy. Once the enrollee exceeds the benefit limit as established by the department, 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. 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 denial to file an appeal. For more information on appeals, please refer to the **Kentucky Medicaid Provider Manual**.

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

Written submission

Providers can submit appeals in writing to:

Humana Provider Correspondence Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546

Fax: **800-949-2961**

Digital submission
Providers can submit encrypted appeal supporting documentation online via **Availity Essentials™**. Providers also can check appeal status via **Availity Essentials.**