Humana Healthy Horizons in Kentucky Policies Booklet

For providers who render services to our Humana Healthy Horizons® in Kentucky enrollees, please review the important policies information contained.

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.

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 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 in rendering appropriate care. Identification of selected brand names of 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. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, electronic, mechanical, photocopying or otherwise, without permission from Humana Healthy Horizons.

Humana
Healthy Horizons®
in Kentucky

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Document change log

Date	Policy	Comments
7/1/2025	Expanded retrospective review policy – revised August 2024	Added to booklet
6/3/2025	Out-of-network claim payment policy	Added to booklet
6/4/2025	Peer Support Claims Covered Services Limitation Policy	Added to booklet
7/10/2025	Psychoeducation Claims covered Service Limitation Policy	Added to booklet
1/1/2025	Senate Bill 111 Treatment of Stuttering	
11/20/2024	Facility and Non-Facility NA Indicator Humana Claims Payment Policies Long-Acting Reversible Contraception While Inpatient Postpartum Modifier 52 (Revised) Multiple Evaluation and Management (EM) Services Status B Codes Neonatal Intensive Care Unit (NICU) DRG Guidelines(Revised) National Drug Code Billing Requirement Physician Administered Drugs	
10/1/2024	Medicaid Provider External Independent Review (EIR) Intake Form	Added to booklet
6/21/2024	Durable medical equipment (DME) claims payment Durable medical equipment rental Emergency department E/M reimbursement Expanded retrospective review Fee schedule IMD requirements and Humana reimbursement Modifier 52 & 53 billing Modifier 78 billing Neonatal Intensive Care Unit (NICU) claims payment Out-of-network claims payment Peer support payment Psychoeducation payment Required forms: notice completion, retention and claim submission SUD 1115 Waiver Billing requirements Urine drug testing Venipunctures, evaluation and management (EM) services	

Hyperlink list of Humana Healthy Horizons in Kentucky policies:

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

Anesthesia modifier billing — 7/1/22

Bypass for Commercial Codes — 5/1/23

Bypass for Medicare Codes — 5/1/23

Durable medical equipment (DME) claims payment — 1/21/21

Durable medical equipment rental — 3/1/24

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 and Humana reimbursement — 1/1/20

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

Long-Acting Reversible Contraception While Inpatient Postpartum

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

Modifier 52 & 53 billing — 3/1/24

Modifier 52 (Revised)

Modifier 78 billing — 3/1/24

Multiple Evaluation and Management (EM) Services

National Drug Code Billing Requirement

Neonatal Intensive Care Unit (NICU) DRG Guidelines (Revised)

Out-of-network claims payment — 7/5/25

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

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

Physician Administered Drugs

Required forms: notice completion, retention and claim submission — 1/1/22

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

Sexually transmitted infection testing — 1/1/24

Status B Codes

SUD 1115 Waiver billing requirements — 11/1/22

Urine drug testing — 7/1/20

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

Viral hepatitis serology — 1/1/24

Vitamin D testing — 1/1/24

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

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— 7/5/25

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 — 1/1/25

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 —10/1/24

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
  - Post mark 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 — 8/1/24

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**
- Fax: **833-974-0059**

Providers can view authorization status, along with the authorization number associated with the request at **Availity.com**. SSome 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 — 3/1/24

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 — 3/1/24

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 — 3/1/24

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.

Durable medical equipment rental — 3/1/24

Humana Healthy Horizons wants to remind our durable medical equipment suppliers of claims payment guidelines relating to the rental of durable medical equipment.

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 10th 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 — 3/1/24

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 — 1/1/24

Coverage

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

- Diagnosis code1 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

- **A56798– Expected Dx codes for Vitamin D Testing (LCDs)**
- **National Institute of Health**
- **National Library of Medicine**
- **US Preventive Services Task Force (USPSTF)**
- **L33996 – CMS coverage guidelines for Vitamin D Testing (LCD)**

Viral hepatitis serology — 1/1/24

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

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

Sexually transmitted infection testing — 1/1/24

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

- **Centers for Disease Control and Prevention (CDC)**
- **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**
- **AMA Current Procedural Terminology (CPT®) Professional Edition and associated publications and services**
- **Cabinet for Health and Family Services**

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

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 — 8/14/23

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 — 7/23/23

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/ClaimPaymentPolicies**. 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 — 7/1/23

Humana Healthy Horizons in Kentucky recently updated its payment policy for diagnosis-related group (DRG) claim reimbursement for Neonatal Intensive Care Unit (NICU) services. The updated policy clarifies criteria for the appropriate selection of DRG codes. The policy becomes effective for dates of admission on or after 7/1/2023.

Please review the new claims payment policy at Humana.com/ClaimPaymentPolicies. Enter NICU in the keyword search and look for NICU Claims Payment Policy, effective date 7/1/2023.

Bypass for Medicare Codes — 5/1/23

The Kentucky Department for Medicaid Services (DMS) developed the Medicaid Bypass Lists for Medicare noncovered codes to allow healthcare providers to bill Medicaid managed care

organizations directly without the requirement to provide an Explanation of Benefits or Medicare primary payer information on the claim. Kentucky DMS announces updates to these lists with varying effective dates. Humana Healthy Horizons in Kentucky initiates configuration updates based on the changes described in the list update.

Humana Healthy Horizons no longer performs claim adjustments for previously paid claims based on Kentucky DMS updates to the Medicaid bypass lists for Medicare noncovered codes that have retroactive dates, unless required by Kentucky DMS, as documented on our website at **https://www.humana.com/provider/medical-resources/kentucky-medicaid/fee-schedules**.

These Kentucky DMS lists are specific to provider type, claim type, procedure, revenue, diagnosis codes and date range. As Medicare does not typically cover these codes, Medicaid acts as primary payer without the need for proof of Medicare claim processing. Claims submitted that do not meet all bypass requirements are denied when submitted to Humana Healthy Horizons without a required Explanation of Medicare Benefits for appropriate coordination of benefits.

To download copies of the most up to date bypass lists, please select the following websites and save the linked spreadsheets:

Provider Type 30 (Jan. 17, 2024)

All Provider Types (Jan. 17, 2024) (Except Provider Type 30)

Provider Type 30 (March 17, 2022)

All Provider Types (March 17, 2022) (Except Provider Type 30)

Provider Type 30 (Oct. 12, 2021)

All Provider Types (Except Provider Type 30) (Oct. 12, 2021)

Provider Type 30 (Sept. 8, 2021)

All Provider Types (Except Provider Type 30) (Sept. 8, 2021)

Provider Type 30 (Dec. 15, 2020)

All Provider Types (Except Provider Type 30) (Dec. 15, 2020)
(**http://apps.humana.com/marketing/documents.asp?file=3967548**)

Bypass for Commercial Codes — 5/1/23

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://apps.humana.com/marketing/documents.asp?file=5118724**

Medicaid Bypass for Commercial Code List: **https://apps.humana.com/marketing/documents.asp?file=5118711**

Out-of-network claims payment — 7/5/25

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.

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

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

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 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**.

SUD 1115 Waiver billing requirements — 11/1/22

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 Rehabilitiation Facilties (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 — 7/1/22

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 — 1/1/22

Humana Healthy Horizons in Kentucky recently updated its policy to allow either medical records or completion of a designated form as documentation when submitting early elective delivery claims.

As a reminder, Humana Healthy Horizons in Kentucky requires the completion of specific documentation for the following services:

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

As the provider, you are required to:

- Complete the required documentation according to the appropriate Kentucky Administrative Regulation and/or Humana Healthy Horizons policy.
- Retain the completed documentation as part of an enrollee's chart in the event of a Kentucky Department for Medicaid Services audit on request.
- Refer to the References and documentation section of this notice to review the documentation requirements when completing and submitting via the paper claim process for:
  - Abortion (must include pre-op notes, post-op notes, the physician certificate and the report ofabortion form)
  - Early elective delivery (may submit form or pertinent medical record)
  - Hysterectomy
  - Sterilization

Please mail paper claims to:

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

Please note: Claims for these services must include the appropriate form(s) and/or pertinent medical record, including Coordination of Benefits information.

Notify us of an enrollee's election of the Medicaid hospice benefit as you would when submitting a request for prior authorization.

Claims remain unpaid until the provider submits the required documentation for the applicable service, as detailed in this notice. In the event that Humana Healthy Horizons in Kentucky erroneously pays a claim without the required form or pertinent medical record, Humana Healthy Horizons in Kentucky may initiate overpayment recovery efforts, per regulatory and contractual requirements.

References and documentation

Abortion VS_913_04.2020_Report of Abortion

CHFS_ACR_2.2020_Abortion Certification Requirements

Early elective deliveries Early elective Deliveries (EED) Prior to 39 weeks Gestation_06232017

Addendum to 06232017 EED Prior to 39 Weeks Gestation

You can submit either the checklist below or the pertinent medical record, found at

The American College of Obstetricians and Gynecologists Patient Safety Checklist

Hospice Medicaid Benefit election MAP374_Election of Medicaid Hospice Benefit

Hysterectomy Map251_Hysterectomy Consent Form

Sterilization OMB_09370166_Consent for Sterilization

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

Durable medical equipment (DME) claims payment — 1/21/21

Effective June 21, 2021, Humana Healthy Horizons in Kentucky no longer accepts claims with a "NU" modifier for DME. 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 DME.

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

Urine drug testing — 7/1/20

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**.

IMD requirements and Humana reimbursement — 1/1/20

Humana Healthy Horizons in Kentucky covers short-term stays in an institution for mental disease (IMD), including an inpatient stay in an IMD for psychiatric or substance-use disorder, for enrollees ages 21 to 64 permitted by the Centers for Medicare & Medicaid Services. Humana Healthy Horizons in Kentucky does not require an enrollee to receive services in an IMD.

The Social Security Act at 42 CFR 435.1010 defines an IMD as an institution with more than 16 beds that primarily engages in the diagnosis, treatment or care of persons with mental diseases. In 2016, the Medicaid and CHIP Managed Care Final Rule 42 CFR 438.6(e) permits states to pay managed care organizations (MCOs) for individuals ages 21 to 64 who are a patient in an IMD. The coverage is available only for short-term stays in an IMD. A short-term stay is no more than 15 days. In addition, the services provided would have to meet 42 C.F.R. Part 438.3(e)(2) as "in lieu of services" that are medically appropriate, cost-effective substitutes for the services that are otherwise be available. In 2018, Kentucky MCOs were authorized by the Kentucky Department for Medicaid Services (DMS), at their option, to authorize coverage for short-term stays.

These 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 in Kentucky reimburses for IMD services as follows:
- No more than 15 days in a given month for inpatient psychiatric treatment
- 30 days per admission for IMD for Residential Treatment for Substance Abuse as permitted by the currently approved 1115 SUD Waiver. In order to be eligible for this reimbursement

providers must have attested to providing treatment according to the ASAM Levels of Care Criteria (**https://chfs.ky.gov/News/Documents/nrsud.pdf**).

IMD facilities located outside Kentucky

Facilities located outside Kentucky are not eligible for Kentucky DMS and Humana Healthy Horizons in Kentucky claims reimbursement. Humana Healthy Horizons in Kentucky cannot reimburse IMD facilities located outside of Kentucky, as Kentucky DMS does not enroll out-of-state adult psychiatric hospitals. These facilities would follow their state's guidelines for billing for these services.

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.