Behavioral Health Authorization Resumption FAQ

General questions

What day will authorization requirements return?

Authorization requirements will begin on Tuesday, July 1, 2025. Prior to July 1, Humana Healthy Horizons® in Kentucky offers opportunities to submit authorization requests for review. Please review the informational deck reviewed during our provider webinars or the May 30, 2025, network notice for further details.

Will the information shared during the provider webinar be available?

The informational slide deck presented during the provider webinar was sent to all attendees following the end of the webinar. Additionally, Humana Healthy Horizons will post the informational deck and a recording of the training to our provider training materials website.

How do I make sure Humana Healthy Horizons has our correct phone number, email and fax?

You may check with your Provider Services representative to ensure that we have up-to-date contact information for you and your practice. Additionally, you can verify the correct points of contact for each authorization request at the time of submission.

Will there be a grace period?

Humana Healthy Horizons has a designated go-live date aligned with Kentucky Department for Medicaid Services (DMS) requirements for July 1, 2025. Authorization requirements will begin on this date. If you encounter challenges, we encourage you to contact Humana Healthy Horizons so we can help.

We recommend taking advantage of the early submission opportunity to address questions and resolve concerns related to the authorization process. Don't hesitate to contact your Provider Services Representative or behavioral health utilization management (UM) leadership for assistance as questions arise. We are here to help you navigate this process.

If a patient is utilizing services that will extend beyond July 1, will preauthorization be required before July 1 or are authorization requirements only for new patients?

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If a patient currently utilizes affected services to be received beyond July 1, 2025, authorization is required. Authorization requirements apply to all services listed on the prior authorization list (PAL) for dates of service on or after July 1, 2025, for existing or new patients.

Submitting authorization requests and clinical information

How do I submit authorization requests?

Authorization requests can be submitted via the following:

- Phone: 800-444-9137
- Fax: 833-974-0059
  - **Please note:** We ask that all fax requests include an Authorization Request Form.
- Availity Essentials™
  - **Please note:** We ask all providers to document the service requested, number of units and dates of service in the notes section of the request to support quality control.

Is prior authorization required for patients 18 years and younger?

Yes, authorization is required for all members for the codes identified on the PAL. Codes identified for authorization were reviewed and approved by Kentucky DMS for use with our membership, regardless of age.

What exactly do I need to submit with my authorization request?

Humana Healthy Horizons requires all authorization requests include comprehensive clinical information. This information should detail the member's current presentation, needs and the intervention plan designed to assist the member in achieving optimal health outcomes.

How often does Humana Healthy Horizons require submission of new treatment plans/needs assessments?

Although Humana Healthy Horizons doesn't specify how often a treatment plan or needs assessment should be updated, we advise that treatment plan information should be reviewed prior to submission of updates on a member's status for authorization. It is essential to provide updated clinical information that indicates progress towards treatment goals or, if applicable, the reasons for lack of progress. Additionally, it is important to outline changes or updates to the treatment plan that result from the member's progress or lack thereof. Lastly, Humana Healthy Horizons advises review of regulations and requirements for each service provided to determine if specific requirements to the frequency of assessment or treatment planning are needed.

What are units?

The term unit is often used when discussing authorization requests.

Units are defined within the reimbursement provisions and requirements regulations specific to each provider type:

Section 2. Reimbursement.
(1) One (1) unit of service shall be:
(a) Fifteen (15) minutes in length unless a different unit of service exists for the service in the corresponding:
1. Current procedural terminology code; or
2. Healthcare common procedure coding system code; or
(b) The unit amount identified in the corresponding:
1. Current procedural terminology code if an amount is identified in the current procedural terminology code; or
2. Healthcare common procedure coding system code if an amount is identified in the healthcare common procedure coding system code.

How quickly will I receive a decision about my request?

As detailed in your contract, all requests for substance use disorder services (inpatient and outpatient) must be completed on an expedited (i.e., 24-hour) turnaround time.

All other inpatient services are completed on a 24-hour turnaround time.

All other outpatient services are completed within a 5-day turnaround time.

All retrospective reviews are completed within a 5-day turnaround time.

The clock for turnaround time starts when a request is submitted to Humana Healthy Horizons (i.e., when a fax is submitted, a call is made or an Availity Essentials submission is completed).

Providers can submit an expedited authorization request (meaning their request would be completed within 24 hours) in the event the standard time frame listed above could seriously jeopardize a member's life or ability to attain, maintain or regain maximum function. If a provider wants an expedited turnaround time, they need to indicate so on their initial request.

What provider types are classified as qualified health care professionals on diagnosis reports?

Qualified health care professionals (QHCPs) include individuals who possess the appropriate licensure to diagnose and treat a condition. This encompasses a range of professionals, including medical doctors or doctors of psychology. Additionally, reports signed by advance practice registered nurses (APRNs) or nurse practitioners also are accepted, provided they operate within the scope of their licensure.

Can authorization be granted without a diagnosis?

A diagnosis is required to support an authorization request.

Can I obtain authorization before an initial evaluation?

Authorization is not granted unless valid clinical information is submitted to support a request. Authorization requests must include clinical information that supports why the service is required and is medically necessary. We leave it to the provider's discretion as to what clinical information supports a request. In the event the clinical information submitted is not sufficient, a UM staff member will contact you to request further information that supports your request.

How long in duration are authorization approvals issued?

There is no standard duration for authorization approvals. Each case is evaluated on an individual basis, and the duration of authorization approval depends on the specific circumstances surrounding the case. The intensity and duration of the service must meet medical necessity criteria to be approved. Therefore, the approval period can vary depending on the individual needs of the client and the services requested.

How is treatment progress assessed?

Treatment progress is assessed on a case-by-case basis. Generally, progress is gauged by measurable advancements towards treatment goals outlined in the individual's person-centered treatment plan. This may include improvements in symptoms, enhanced functioning, and the achievement of specific objectives collaboratively set between the provider and the member.

Once previously approved outpatient services are nearing completion, how soon before the existing authorization approval ends can we submit a request for additional units?

There is no specific deadline to which providers must adhere when seeking additional services beyond what was already authorized. Before submitting a request for additional units of service, it's important to have clinical information in hand to demonstrate the member's progress during the previous authorization period. We recommend initiating the request for additional services when you have the necessary clinical information to discuss the progress already achieved and to outline the focus for the additional units of service.

If I obtain authorization for a service and the treating provider needs to make a permanent or temporary change to a treatment service, do we need to submit a new prior authorization request?

In this instance, if the billing provider does not change, a new authorization request would not be required.

Are there diagnosis requirements or age caps for services affected by this authorization requirement?

We encourage you to review the Milliman Care Guidelines (MCG) or American Society of Addiction Medicine (ASAM) criteria related to the services requested, as these criteria inform medical necessity determinations. All limitations identified within the criteria influence authorization decisions.

Additionally, some services have requirements, age caps and limitations outlined in regulation. We encourage providers to familiarize themselves with Kentucky regulations pertaining to the services they request.

If a member transfers to a different inpatient or residential location within the same provider group (i.e., same National Provider Identifier and Tax Identification Number) and within the duration of the days previously approved, would a new authorization request be required? Would the previously approved days/units be honored?

You need to submit a new authorization request and specify that it is a change in location from the previously approved request. The units approved at the previous location are honored in the new request, provided the member has not experienced gaps in treatment (e.g., a discharge in which the member was not under the care of the provider overnight). Additionally, it is considered best practice to include the authorization number of the previously approved dates of service with your new request.

If all the dates approved for an outpatient service are not used by the end date, can I ask for the dates to be extended?

If dates of service for outpatient services are not fully used, you can request an extension. Providers should contact the Humana Healthy Horizons behavioral health UM team to indicate the need for extension.

Medical necessity criteria

When will Humana Healthy Horizons transition to ASAM 4th edition?
The transition to the ASAM 4th Edition criteria occurs on July 1, 2025. This transition is in alignment with the mandate from Kentucky DMS and takes place concurrently with the resumption of authorization requirements.

Can you verify what level-of-care review criteria will be used to determine medical necessity (e.g., Level of Care Utilization System, ASAM, Child and Adolescent Service Intensity Instrument, etc.)?

All requests for substance use disorder services are reviewed using ASAM 4th edition criteria.

All requests for mental health services are reviewed using MCG criteria.

In the event criteria utilized for a service changes, providers receive notice in advance of that change.

Discharge notifications

Humana Healthy Horizons expects providers to notify us when a member intends to discharge or has discharged from an inpatient level of care. This notification allows us to support members postdischarge and follow up.

How do I submit discharge information?

Discharge information can be faxed to 833-660-0265 or emailed to kybhmcddc@humana.com.

Can discharge information be uploaded to Availity Essentials?

Discharge information upload via Availity Essentials is not currently an available option.

Do I need to submit discharge information regarding outpatient services?

Discharge information for outpatient services is not required but is encouraged to help support member follow-up.

Denials and peer-to-peers

What happens when my request is denied?

When a request is denied, you will receive a call from a UM staff member to notify you of the denial. Additionally, you will receive a denial letter via fax indicating why the request was denied and steps to take if you wish to pursue a peer-to-peer or file an appeal.

What is needed to file an appeal?

Detailed appeal guidance is provided on every adverse benefit notice (denial letter). This information outlines the necessary steps and requirements for filing an appeal.

Who can complete a peer-to-peer discussion?

The determination of who is most appropriate to engage in a peer-to-peer discussion with a Humana medical director is left to the discretion of the provider. It is essential that the individual chosen can answer questions related to the necessity of the service.

Examples of individuals who may be suitable for this discussion include:

- Clinicians (both independently licensed and those under supervision)
- Targeted case managers
- Nurses
- Psychiatrics
- Nurse practitioners

Additionally, it is permissible for multiple members of the treatment team to participate in the peer-to-peer discussion if the provider feels this allows for a comprehensive response to clinical questions.

How quickly are peer-to-peer discussions scheduled?

Humana Healthy Horizons requires all providers to request a peer-to-peer discussion within 5 business days of the denial decision. We make every effort to schedule the peer-to-peer discussion as quickly as possible; however, scheduling requires advance notice for our medical directors and is subject to their availability.

Confidential voicemail

Humana Healthy Horizons requires voicemail be made confidential to leave all protected health information regarding an authorization request secure.

What is required for a secure voicemail inbox?

For behavioral health UM associates to leave information related to your request on voicemail, your outgoing voicemail message must indicate:

- The name of the person contacted
- The name of the provider
- A statement that the voicemail is confidential

If the details listed above are not on the outgoing message, a generic message requesting a return call is left.

Availity Essentials

Will there be additional training available on Availity Essentials?

If you would like training on how to navigate Availity Essentials submissions, please contact your Provider Services representative to arrange a session. Additionally, there are numerous self-serve options you can use from Humana's provider website.

Should I submit an Authorization Request Form when submitting a request via Availity Essentials?

It's not required to submit an Authorization Request Form when submitting through Availity Essentials; however, doing so can speed the processing of your request. If you choose not to submit the Authorization Request Form, we ask that you include the following information in the notes section of your Availity Essentials submission to support quality control:

- Service requested
- Number of units
- Dates of service

Availity Essentials does not offer a space to add clinical information. Should I add a "Service Plan?" Are there other ways to report clinical information for authorization consideration?

Currently Availity Essentials does not permit attaching clinical documents when making your initial authorization submission. After completing other portions of the request, select "submit" on the request. Then go back into the authorization request and Availity Essentials allows you to attach documents. This ensures information is attached for review when our team receives the submission.

Points of contact

Humana Healthy Horizons welcomes all questions about the authorization process. Please contact us if you have concerns or questions as you navigate authorization submission.

How do I find my provider representative?

A listing of current provider representatives is available on our Provider Services representative assignment list.

Who can I talk to on the UM team if I have concerns?

In the event you need to speak with behavioral health UM leadership, please pursue the following contacts:

- Rob Brooks, LCSW, LCADC – Manager of Inpatient Behavioral Health UM
  Rbrooks29@humana.com
- Michelle Brown, LMFT – Manager of Outpatient Behavioral Health UM
  Mbrown214@humana.com