Behavior Analysis Provider Questionnaire

The following frequently asked questions detail Humana Healthy Horizons® in Florida's guidance related to behavior analysis services. These services are available to our members younger than 21.

Clinical/Utilization management

Question	Answer
What is Humana Healthy Horizons' approach concerning existing authorization?	• Humana Healthy Horizons will honor all eQHealth/Acentra approval letters through at least May 31, 2025. • If the eQHealth approval ends after May 31, 2025, Humana Healthy Horizons will continue approval through the end date of the approval letter as long as the request appears to be within the Agency for Health Care Administration (AHCA) guidelines. • If the eQHealth approval ends before May 31, 2025, Humana Healthy Horizons will extend the end date/last day of that authorization to May 31, 2025. However, Humana Healthy Horizons will not necessarily increase the number of units to last through the time period between the approval end date and May 31, 2025. – For example, if eQHealth approval ends March 30, 2025, the member may run out of available approved units before May 31, 2025. Humana Healthy Horizons encourages providers to request full authorization before that occurs. For this example, submit a request for treatment to begin March 31, 2025, for full 6-month authorization and include all necessary clinical documentation for Humana Healthy Horizons to review for medical necessity. • Humana Healthy Horizons adds up to 18 units of 97151-TS to the eQHealth approval to assist with simplifying the authorization process, allowing providers to reassess the member before the next treatment authorization request. Humana Healthy Horizons encourages providers to include 97151TS with all treatment authorization requests, as only 1 authorization per 6 months is required (unless member behaviors change requiring reauthorization).

Humana
Healthy Horizons®
in Florida

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Question	Answer
	• If the authorization expired prior to the end of the continuity of care (COC) period, please request new authorization. • For members transitioning from another managed care organization (MCO), please submit a new authorization request to Humana Healthy Horizons, and provide the approval notification from the previous MCO so we can honor that authorization through the 120 day COC period beginning when member transitioned to Humana Healthy Horizons.
How do we submit a new authorization request?	• Call the Humana Healthy Horizons intake team at **866-856-8974**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time. • Call Availity Client Services at **800-282-4548** to register for an Availity Essentials™ account. • Visit the **Humana Healthy Horizons Learn About Availity webpage**. • Fill out the **Behavior Analysis Authorization form** with the required documentation and fax it to **813-321-7220**. Please use the following resources available in the Behavior Analysis Clinical Toolkit on the Humana Healthy Horizons provider website • **Behavior Analysis Informational Flyer** (provides resources about Availity Essentials) • **Behavior analysis clinical toolkit** Authorization requests are reviewed within 5 calendar days. If additional information is needed, the utilization management team will reach out by phone or fax. Please ensure accurate contact information is submitted with the request.
When the authorization expires, should we first request a re-evaluation, like we did in eQHealth?	Providers are encouraged to submit reassessment requests at the same time as requesting recertification for continued treatment. An updated behavior plan is required every 6 months to authorize treatment services. Behavior Assessment System for Children (BASC)/Vineland findings are also required in the behavior plan, updated at least annually.
If a member is currently with Humana, but they are in the process of transitioning to another MCO, how does that transition work in terms of authorization?	• An authorization request must be on file with Humana Healthy Horizons for any claims to be filed during the time the member is covered by Humana Healthy Horizons. • For members transitioning from another MCO, please submit a new authorization request to Humana Healthy Horizons, and provide the approval notification from the previous MCO so that we can honor that authorization through the 120 day COC period beginning when member transitioned to Humana Healthy Horizons.
How can we obtain the Humana-specific authorization number for this member?	Search for the member in Availity Essentials or call our intake team at **866-856-8974**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Question	Answer
How do we let you know that your clients are receiving services from our organization?	• Thanks to the information provided by AHCA, Humana Healthy Horizons should know about most members. If you are unsure, you can call the intake team at **866-856-8974** and ask if we have authorization on file for that member. • If we do have authorization, our intake team can provide you with faxed approval notification. • If we do not have authorization, please provide us with the approval letter for the member's last authorization, and we will make sure authorization is created in our system as well.
What is the process to follow when the client changes agencies in the middle of a prior authorization period?	The new provider must submit an authorization request for the rest of the initial provider's dates of service, and include the previous provider's clinical documentation (e.g., Comprehensive Diagnostic Evaluation [CDE], BASC, Vineland, behavior plan) and a signed and dated document from the member's guardian stating that they would like to change behavior analysis providers.
What are the requirements regarding CDE?	Humana Healthy Horizons requires a CDE and referral on file for each member. The age of the CDE and referral is not important to Humana Healthy Horizons, currently. Please send the CDE and referral you have on file for each member when you submit the first authorization request for that member. We allow a grace period of 6 months for each provider to obtain the CDE and referral when necessary.
Is the CDE needed every 6 months?	No. We need it on file for each member on at least 1 authorization. Please send the CDE and referral you have on file for each member when you submit the first authorization request for that member, if possible.
How old can the CDE be?	Humana does not have a time limit on the CDE and M.D. referral.
Will Humana Healthy Horizons accept a complete psychological evaluation or a letter of medical necessity instead of the CDE?	We will accept what is outlined in the AHCA Behavior Analysis Services Coverage Policy December 2024, section 2.2. "The recipient must be referred by an independent physician or practitioner qualified to assess and diagnose disorders related to functional impairment, including: • Primary care physician with family practice, internal medicine, or pediatrics specialty • Board certified or board eligible physician with specialty in developmental behavioral • Pediatrics, neurodevelopmental pediatrics, pediatric neurology, adult or child psychiatry • Child psychologist The referral must include a physician's order for behavior analysis services and a comprehensive diagnostic evaluation (CDE) performed according to national evidence-based practice standards. CDEs may be performed by a

Question	Answer
	multidisciplinary team or individual practitioner. In any case, the CDE must be led by a licensed practitioner working within their medical, developmental, or psychological scope(s) of practice. The CDE must include assessment findings and treatment recommendations appropriate to the recipient. For example, the CDE may include data from behavioral reports by parents, guardians, and/or teachers; diagnostic testing related to recipients' development, behavior, hearing, and/or vision; genetic testing; and/or other neurological and/or medical testing."

Claims submission

Question	Answer
Do we need to submit the claims through Availity Essentials using Humana Healthy Horizons as the payer?	Availity Essentials is Humana Healthy Horizons' preferred clearinghouse. However, providers have the option to use other clearinghouses or submit paper claims.
How do we view claims on the remittance in Availity Essentials?	• In the Availity Essentials menu bar, select Claims & Payments > Remittance Viewer. • On the Remittance Viewer landing page, select Remittance Viewer. – Be sure to verify you have access to your payments by selecting Manage Access on the Remittance Viewer page. • Once you have access to your payments in remittance viewer, you will be able to access your explanation of payment/explanation of benefits (EOP/EOBs) from the Check/electronic funds transfer (EFT) tab or Claim tab (in the remittance viewer). – **Tip:** To find the EOP/EOBs for a particular Tax ID, do the following: ▪ Enter the Tax ID in the Search field on the Check/EFT tab and select Payee Tax ID from the dropdown. ▪ Select Search. • For additional assistance, please call Availity Client Services at **800-282-4548**, Monday – Friday, 8 a.m. – 8 p.m., Eastern.
How long does it take for claims to be reflected in Availity Essentials?	Electronic submission may take up to 10 business days, and paper claim submission may take up to 15 business days.
How long does it take to receive paper checks?	• Paper checks can take 7–10 business days to be received.

Question	Answer
Who can bill for rendering services?	Per the Behavior Analysis Coverage Policy under 3.2, services must be rendered by one of the following: • Lead analysts who are one of the following: – Board-certified behavior analyst (BCBA) credentialed by the Behavior Analyst Certification Board® – Florida-certified behavior analyst (FL-CBA) credentialed by the Behavior Analyst Certification Board – Practitioner fully licensed in accordance with Chapters 490 or 491, F.S., performing within their scope of practice – Board-certified assistant behavior analysts (BCaBA) credentialed by the Behavior Analyst Certification Board working under the supervision of a BCBA – Registered behavior technicians (RBT) credentialed by the Behavior Analyst Certification Board working under the supervision of a BCBA or BCaBA
Who should be the rendering or treating provider?	• According to the **Medicaid Provider Reimbursement Handbook, CMS-1500**, enter the individual rendering (treating) provider's number in Item 24 J. Enter the rendering provider's ID number only when it is different from the pay-to provider number entered in items 33a or 33b. • If the rendering provider is the pay-to provider, the rendering provider would be captured in 33a or 33b.
Do BCBAs and RBTs require a Medicaid provider to render services?	Providers rendering services to Florida Medicaid beneficiaries are required to have an active Medicaid ID at the time services are rendered.
Do you have a preference on which policy number is used on claims moving forward beyond the COC period?	Be sure to use the member's Humana Healthy Horizons ID number on claims moving forward beyond the COC period.
Is there any specific diagnosis code that is not reimbursable?	According to the **Behavior Analysis Services Coverage Policy**: • 8.4 Diagnosis Code—Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service. • 8.4.1 Co-occurring Disorders—Providers must report diagnoses of co-occurring disorders that may impact the medical necessity for behavior analysis services.

Question	Answer
Are we submitting the 97151-TS along with service codes or separately?	If the provider has rendered 97151-TS along with additional behavior analysis services, the services can be submitted on the same claim.
Is the XP modifier required to billed on claims?	• Yes, Florida Medicaid requires the use of the XP modifier for reporting time spent under supervision with the recipient present, specifically for BCaBA when the BCBA delivers service code 97155, and in all other instances for the supervisee's time. • Supervision reporting: Florida Medicaid uses specific Current Procedural Terminology (CPT®) codes for behavioral analysis services, and the XP modifier is used to indicate that a service was performed by a separate practitioner (the supervisee). Specific Use of XP: • 97155 XP: Report this code when a BCaBA is receiving supervision while the BCBA delivers service code 97155 (Qualified Health Professional Services). • 97153 XP: Use this code for all other instances to report the supervisee's time. • Be sure to bill $0.01 when billing 97153-XP or 97155-XP with the appropriate corresponding CPT codes.
Do we bill $0.01 for XP Modifier or $0.0?	There is not a diagnosis requirement specifically; it can be other diagnoses besides F84.0 for either initial assessment/CDE and treatment requests. Humana Healthy Horizons needs a specific diagnosis based mainly on the member's behaviors showing medical necessity criteria. The member's specific diagnosis is less important.
What are the acceptable CDE diagnostic codes for approval?	According to the **Behavior Analysis Coverage Policy**, the recipient must be referred by an independent physician or practitioner qualified to assess and diagnose disorders related to functional impairment, including: • Primary care physician with family practice, internal medicine or pediatrics specialty • Board-certified or board-eligible physician with specialty in developmental behavioral pediatrics, neurodevelopmental pediatrics, pediatric neurology, adult or child psychiatry • Child psychologist The referral must include a physician's order for behavior analysis services and a comprehensive diagnostic evaluation (CDE) performed according to national evidence-based practice standards. CDEs may be performed by a multidisciplinary team or individual practitioner. In any case, the CDE must be led by a licensed practitioner working within their

Question	Answer
	medical, developmental, or psychological scope(s) of practice. The CDE must include assessment findings and treatment recommendations appropriate to the recipient. For example, the CDE may include data from behavioral reports by parents, guardians, and/or teachers; diagnostic testing related to recipients' development, behavior, hearing, and/or vision; genetic testing; and/or other neurological and/or medical testing.

Contracting

Question	Answer
Are you accepting new providers?	Yes. Humana Healthy Horizons is accepting new providers based on membership requirements and the network's needs.
What is the time frame to know if the request to contract is approved?	Humana Healthy Horizons will respond to requests to join the network within 90 days.
What will the rate be after COC period ends?	The rates will be subject to negotiation.
What would be the rate after COC period ends?	The rates will be subject to negotiation.
Do we have to be in-network to sign up for EFT?	Yes, only contracted providers can enroll in EFT.
How can we obtain a single case agreement?	If a member needs service after COC, you can request authorization. If the authorization is approved, you do not need a single case agreement. Bill your claims appropriately, and you should be paid as a nonparticipating provider.
How many days before May 30, 2025, should we send a single case agreement for those out of network?	Request authorizations for cases at least 2 weeks before May 30, 2025.
How often will our providers need to go through recredentialing with Humana Healthy Horizons?	Standard time frames apply—every 3 years.
What determines if there are no other participating providers in the area?	Once you submit an authorization request, and the utilization management team determines there isn't a participating provider in the area with the capacity to provide services to the member, they will review for medical necessity and notify the provider if additional information is needed. Authorization decisions are made within 5 calendar days.

General reminders for behavior analysis providers

- We do not require letters of agreement or single case agreements for any nonparticipating providers at this time. The letters of agreement or single case agreements are not required to continue services with our members. If the provider is registered with AHCA as a Medicaid provider in good standing, we will review authorization requests for medical necessity
- We are required to stay within AHCA guidelines for authorization requests:
  - A maximum of 24 units for 97151 initial assessment
  - A maximum of 18 units for 97151TS reassessment
  - A maximum of 8 units for 97152 with documentation justifying the need
  - A maximum of 16 units for 0326T with documentation justifying the need
  - A maximum of 40 hours per week of intervention services (all CPT codes except 97151 and 97152)
- Initial assessment authorization requires:
  - Members younger than 21 with appropriate diagnosis code to the highest level of specificity
  - Member was referred for behavior analysis services by an independent physician/practitioner qualified to assess/diagnose disorders related to functional impairment (PCP, board-certified/eligible physician, child psychologist) working within their medical, developmental, or psychological scope(s) of practice. Referral includes **all** of the following:
    - A physician's order for behavioral analysis services
    - CDE led by the above qualified physician/practitioner
    - Assessment findings and treatment recommendations
  - Member requires behavior analysis services due to behaviors that impair major life activities, such as functional impairment expressed through **at least one** of the following behaviors:
    - Safety—aggression, self-injury, property destruction, elopement, pica
    - Communication—problems with expressive/receptive language, poor understanding or use of nonverbal communications, stereotyped, repetitive language
    - Self-stimulating—abnormal, inflexible or intense preoccupations
    - Self-care—difficulty recognizing risks or danger, grooming, eating, or toileting
    - Other behaviors not identified above but not limited to complexity of treatment, programming or environmental variables
- Treatment authorization requests require:
  - Behavior assessment, signed by the lead analyst **and** the member's parent/guardian, includes **all** of the following:
    - Identification of behavioral deficits interfering with a major life activity, including events/subsequent interactions that elicit/sustain targeted behavior
    - Member's medical and developmental history, medications, relevant family history **and** review of recent assessments/reports/file review
    - Transition (fading) plan, crisis management plan **and** discharge plan

        - Assessment findings on Vineland-3 for all members—plus maladaptive behavior domain for members age 3 and older; and BASC-3 Parenting Relationship Questionnaire (PRQ) for members age 2-19
            - ◊ These core instruments are included in initial assessment **and** with reassessments every 12 months.
    - Behavior plan, including specific behavior goals, intervention strategies for each goal, anticipated time frames of sufficient duration to address the targeted behavior **and** how the ongoing progress of intervention strategies will be reported
    - Documentation that reflects parental participation **and** training goals, **or** provider's effort to accommodate parental participation **and** explanation of how potential impacts of nonparticipation are being mitigated
    - **If** services are provided in school:
        - Member's individualized education program (IEP)/504 is on file **and** includes behavior analysis services, **or** IEP/504 does not include behavior analysis services: provider includes justification for services, **or** when no IEP/504 is on file: estimated time frame of when IEP/504 will be completed **or** name of school and explanation that neither IEP nor 504 is available
    - Continued-stay treatment authorization requests **also** require:
        - Core instrument findings (Vineland and/or BASC-3 PRQ) are included with reassessments every 12 months.
        - Subsequent assessments and behavior plan include **all** of the following:
            - ◊ Data reflecting progress of all behaviors targeted for improvement **or** explanation for why clinically significant progress was not made and treatment changes to promote progress
            - ◊ Data table and corresponding graph for each behavior under treatment
            - ◊ Narrative discussion of progress **and** statement of justification for continuation of care at the intensity level requested

Provider Relations and other helpful contacts

For participating and nonparticipating providers' general questions and support, please email our behavior analysis Provider Relations mailbox at **FLBA@humana.com**.

Call centers and websites

- Provider call center: **800-477-6931**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time
- Member call center: **800-477-6931**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time
- Interpreter: **877-320-2233**. This is the concierge phone number for the service accessibility line to schedule interpreters.
- **Humana Healthy Horizons in Florida provider website**
- **Behavior Analysis Services Coverage Policy**
- **Provider Reimbursement Schedules and Billing Codes page**