Humana®

Network Notification – Kentucky Medicaid

Notice date: Friday, August 7, 2020
To: Kentucky Medicaid healthcare providers
From: Humana Health Plan
Subject: Updated retrospective review policy
Effective date: Sunday, September 6, 2020

Humana recently identified that the current provider manual does not detail provider retrospective review request submission time frames. Humana will maintain the same submission time frame outlined in the Humana – CareSource® Kentucky Medicaid plan provider manual, as detailed in a Jan. 4, 2019, network notification, with additional clarification provided.

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 requires prior authorization to ensure covered patients receive medically necessary and appropriate services. **Claims that do not meet the necessary criteria as described below are administratively denied.**

Retrospective review policy
Humana only allows for a retrospective authorization submission with request after the date of service, when prior authorization is required but not obtained, in the following circumstances:

- The service is related to another service that already received prior approval and was already performed, and the new service was not needed at the time the original prior-authorized service was performed.
- The need for the new service was determined at the performance of the original prior-authorized service.
- Humana-covered patients who are determined to be retroactively eligible for Medicaid. (Retroactive Medicaid coverage is a period of up to three months prior to the application month.)

The exception to this policy applies only to prior authorizations obtained before an enrollee transitions from another managed care organization to Humana. Humana will uphold the approval for 90 days following the transition.

To request a retrospective review, providers have 90 calendar days from:

- The date of service, or
- The inpatient discharge date, or
- The initial date of a service, for a service that spans several months, or
- The date of the primary insurance carrier's Explanation of Payment or authorization denial, which demonstrates the service was not a covered service.

Requests for retrospective review that exceed the 90-calendar-day time frame are denied and ineligible for appeal.

Humana®

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

How to submit a retrospective review request

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

- Availity.com (registration required)
- Phone/IVR: 1-800-444-9137
- Fax: 1-833-974-0059

For requests submitted via Availity.com or by fax, the provider can check the status online on Availity. Providers can view authorization status, along with the authorization number associated with the request. Some outpatient authorization requests may auto-approve even when the procedure code may not appear on our preauthorization list (PAL). Humana's Kentucky Medicaid PAL is available online at **Humana.com/PAL**. Written notification for approved service requests is not provided unless requested. Requests for written notification can be included when clinical information is submitted or by calling 1-800-444-9137.

If you have questions about this update to the retrospective review process, please call Provider Services at 1-800-444-9137. Hours of operation are Monday through Friday, 7 a.m. to 7 p.m. Eastern time.