Humana Healthy Horizons® in Kentucky: Authorization Resumption for Behavioral Health

Humana Healthy Horizons in Kentucky is a Medicaid product of Humana Health Plan, Inc.

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Humana Healthy Horizons in Kentucky provider website

The provider website is a primary source for information, including:

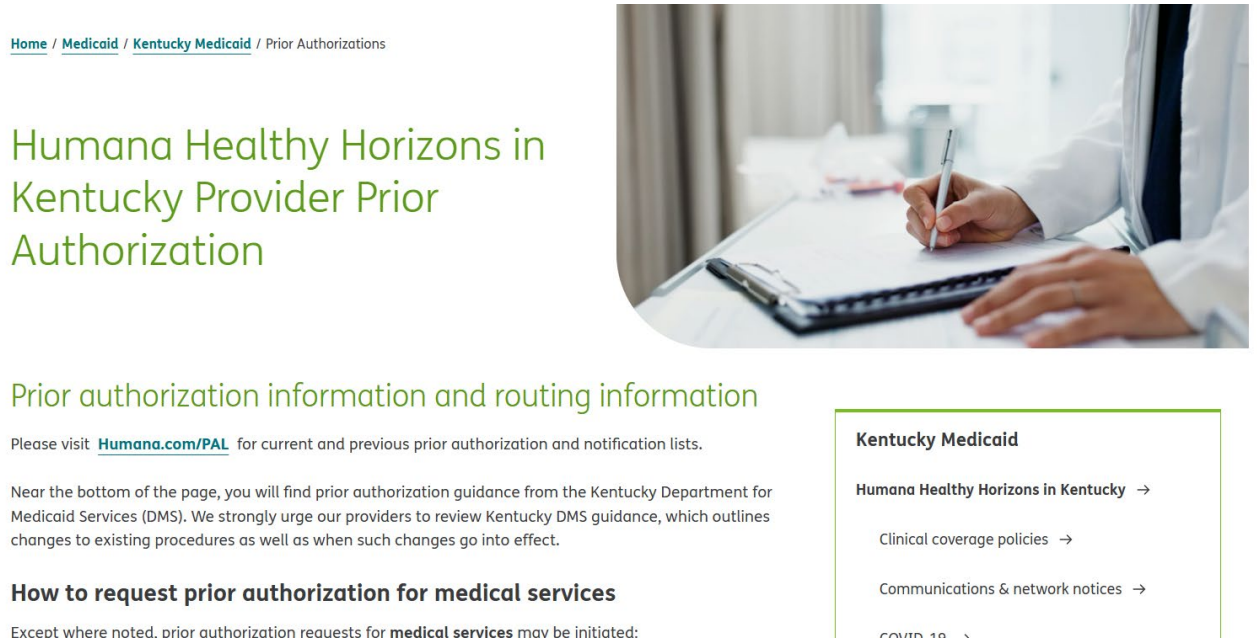
- Clinical coverage policies
- Provider communications and network notices
- Documents and resources
- Links to fee schedules
- Grievances and appeals information
- Prior authorization guidance
- Training materials

[Kentucky Medicaid: Provider Information]

Provider prior authorization website

Our provider authorization website delivers detailed information about:

- How to request prior authorizations
- Forms to include with authorization requests
- Links to the current prior authorization list (PAL)

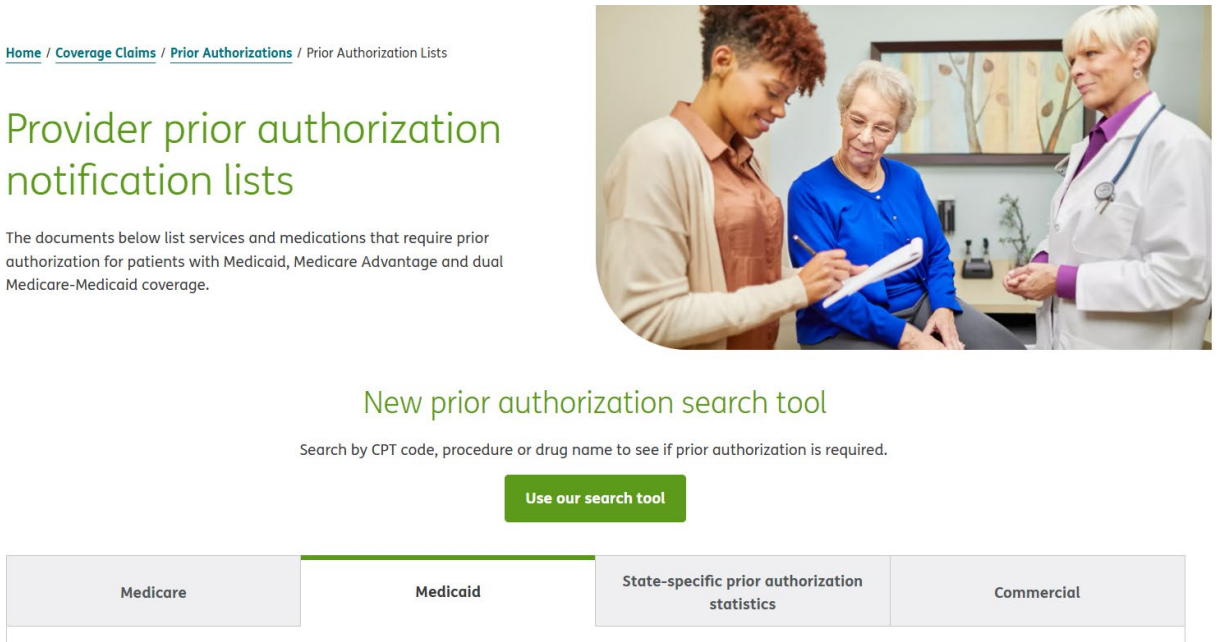


PAL

Humana Healthy Horizons maintains a prior authorization (PA) list that identifies what services require authorization/medical necessity review.

This list is regularly reviewed and updated. Providers are notified of upcoming changes.

We only require authorization for services identified on the PAL. All other services do not require authorization.



Getting started: non-standard PA process for June 2025

Humana Healthy Horizons will implement a non-standard PA process ahead of July 1, 2025, to support request management. Key dates are included on the following slides. Providers who take advantage of early submission can expect the following:

- Service approvals in advance for dates of service July 1, 2025, and later. (No dates of service prior to July 1, 2025, will need to be submitted).
  - Cases where medical necessity is met for the requested services:
    - All dates requested prior to July 1, 2025, are processed as a notification and are communicated verbally to the provider.
    - PA approvals are issued for dates of service from July 1, 2025, forward.
    - PA approval communicated via Availity Essentials™.
  - Cases where medical necessity cannot be determined:
    - All dates requested prior to and through June 30, 2025, are processed as a notification only; Humana Healthy Horizons communicates verbally with the provider that this is **not** an authorization approval.
    - No denials are issued prior to July 1, 2025.
    - Providers are required to resubmit for full clinical review on July 1, 2025.

Key dates

Monday, June 16, 2025

Authorization requests for **outpatient** services to begin July 1, 2025, can begin to be submitted for medical necessity review.

Monday, June 23, 2025

Authorization requests for **all** inpatient and outpatient services that likely extend into and past July 1, 2025, can be submitted for medical necessity review.

Tuesday, July 1, 2025

All inpatient and outpatient services identified on the Humana Healthy Horizons PAL require authorization.

Initial authorization requests

Submissions can occur via:

- Fax
- Phone
- Availity Essentials

Fax and Availity Essentials requests should include all clinical information to support request for services. All requests should include the request form found here.

We may need to contact you to discuss your request, so please provide a contact with confidential voicemail and who can speak to the request made.

Sufficient clinical information

Clinical information should be current and include relevant psychiatric or medical history, history of diagnoses and treatment, current medications (including as needed medications) and vital signs.

- Recent (i.e., within last 24 to 48 hours) notes from various members of the treatment team (i.e., nurses, therapists, psychiatrists) should be included to indicate member's presentation and progress.
- Treatment plan information should include all services, interventions, plans and rationale~~,~~.
- Outpatient service requests should include a listing of all services the member is currently receiving.
- A justification of the necessity for the level of care or service requested should be included.
- Evidence of previous attempts to utilize other or lower levels of care and outcomes should be included.
- An assessment of the member's current functional status and all limitations should be included.
- An assessment of safety risk (e.g., ideation, plans or intent for suicide/homicide, command auditory hallucinations) should be included.
- Outpatient services should indicate the length of time a member has utilized the service requested (e.g., patient received day treatment for the last 6 months) and all progress made.

If insufficient or no clinical information is received, Utilization Management (UM) will make attempts to gain this information by a specified deadline (attempts are made by phone and fax). Failure to provide this information will lead to the case being reviewed by a medical director (MD) for potential denial.

Authorization process

Request submitted

- The provider or delegated representative submits the request for authorization to Humana Healthy Horizons via fax, Availity Essentials or phone.

Review

- The UM team ensures all sufficient info is present and contacts the provider if more information is needed and provides a deadline.
- A UM clinician completes initial review.
- If the assigned UM clinician is unable to approve services based on criteria, the review is routed to a MD for a second review.

Notification

- A decision is made by clinician or MD, as appropriate.
- Provider or delegated representative is contacted via phone to notify of decision.
- If a denial is issued, the provider and member receive a letter outlining the denial and appeal rights.

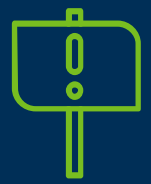
Continued stay review

A continued stay review is undertaken when additional dates of service for an **inpatient** stay are requested. Continued stay review processes are applicable to inpatient levels of care only. Outpatient services may utilize the initial authorization request process for each request.

Best practices – continued stay review

Continued stay reviews. All continued stay reviews are completed live via a telephone call with a Humana Healthy Horizons behavioral health (BH) Utilization Management (UM) staff member. We call on the last covered day to schedule and complete a review. Having a back up staff member in place when your reviewer is out of the office can ensure these reviews are timely and keeps your patient's treatment on track.

Confidential voicemail. For BH UM staff to leave personal health information (PHI) on voicemails related to authorizations, your office's outgoing voicemail message must indicate the name of the facility, the name of the reviewer, and that the voicemail is confidential.



Updated clinical information. Ensuring continued stay clinical information is current and clearly indicates evidence as to why a patient requires the requested level of care helps ensure a quality and efficient review. For each review we ask and pursue person-centered discharge plans. We also ask about plans to resolve treatment barriers post-discharge.

If your request is denied

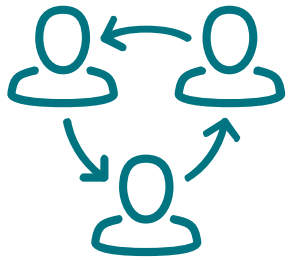
1. You receive a call from the assigned UM staff member to notify you that your request was denied. Please note: The UM staff cannot leave PHI if your voicemail is not confidential.

2. You receive a fax of the denial letter indicating the reason why the request was denied, steps to take if you wish to pursue a peer-to-peer review or file a grievance or an appeal. (Members also receive this letter).

Peer-to-peer review requests can be made within 5 business days of the date of your denial decision. For more information, review the denial letter to understand why the request was denied and how to request a peer-to-peer review, or how to make an appeal that addresses the specific reason the case was denied and details the process of these requests.

Peer-to-peer review requests

If you wish to arrange a peer-to-peer review to discuss the denial decision, you must make your request within 5 business days of the denial decision. If you make a request after 5 business days, you are redirected to Humana Healthy Horizons' Grievances and Appeals department for next steps.



When you make the request, we ask that you list the name of the person whom the Humana Healthy Horizons medical director should contact. This should be a licensed professional who can speak to the member's treatment needs and progress.

After the peer-to-peer review is complete, the medical director has the option to uphold or overturn the denial and approve all or part of the request. If the denial is upheld, you may appeal the denial.

Utilization Management best practices

Confidential voicemail

Confidential voicemail is a voicemail inbox that verbally indicates the following in its outgoing message:

- Name of contact
- Name of facility
- Statement that voicemail is confidential

Contact information

Ensure that each submission has a good phone and fax number so we can easily communicate with the person responsible for the authorization request.

Timely submissions

When a member is eligible on the date of admission or start of service (per KYMMIS), we expect that all authorization requests be submitted within 3 business days of that admit or start. Cases submitted past this time frame are subject to administrative denial.

Notification of inpatient discharge

It is expected that providers notify Humana Healthy Horizons when a member intends or has discharged from an inpatient level of care. This ensures Humana Healthy Horizons can support post-discharge outreach and follow up.

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

In the event discharge and after-care information are not received, Humana Healthy Horizons reaches out to you to request this information.

Discharge information should include the member's home address and phone number, after-care appointments with provider information, and discharge medications.

Retrospective reviews

- In the event a timely submission of an authorization request is not feasible (e.g., eligibility issues), a provider may submit a retrospective review.
- A retrospective review must meet specific criteria to be considered eligible for medical necessity review.
- Additional information can be found in the Humana Healthy Horizons in Kentucky Provider Manual on Page 33, located online on Humana Healthy Horizons' website.

Helpful links/information

Helpful links/information

- Humana Healthy Horizons in Kentucky provider website
- Manager of BH UM contact information
  - Rob Brooks, LCSW, LCADC 270-313-6394/rbrooks29@humana.com
- Humana Healthy Horizons in Kentucky 2025 Provider Resource Guide
- Humana Healthy Horizons in Kentucky Provider Manual
- Availity Essentials
  - How to register for the Availity Essentials portal
- Provider relations representatives
- Authorization Request Form – to be included with all requests
- PAL

Thank you

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