Humana Dental Highlights

A publication of Humana Dental Quarter 1 2026

Good dental health is a journey, and your dentist is the guide. — author unknown

Humana recognizes the exceptional service given to our members by our participating dentists and the critical role this plays in preserving our members' oral health. Humana is committed to our providers, to share relevant information for their dental practice, updates on plan offerings and other dental-related news.

Noteworthy news

2026 Current Dental Terminology code updates

The American Dental Association (ADA) adds, updates or deletes Current Dental Terminology (CDT®) codes as part of its annual code maintenance review. Humana is pleased to share detailed information regarding upcoming changes, which became effective Jan. 1, along with Humana's coverage approach for any newly introduced codes.

Please remember plan coverage varies by product or group benefits, and member benefits and eligibility should be validated on our provider portal www.availity.com. You may also submit a pre-determination or call Humana at the phone number on the back of your patient's ID card. Please refer to our Provider Manual for more information.

Humana updates all fee schedules to include new ADA codes when a similar code was on the fee schedule.

- For example, if a fee schedule included D2931, then D2928 would be added with that fee.
- If the fee schedule did not have a similar/like code listed, we did not include the new code on the fee schedule.

For preferred provider organization (PPO)-based plans, the new CDT codes have been added to our usual customary rate (UCR) tables that will help fee schedules pay to the 80% logic.
To see the full list of additions, deletions and changes online, please view the full list of CDT codes.

Centers for Medicare & Medicaid Services (CMS) QHP Directory Pilot in Oklahoma

The CMS Qualified Health Plan (QHP) Directory Pilot for Oklahoma is live!

What is the CMS QHP Directory Pilot?

- CMS has launched a QHP Directory pilot portal ("the portal") in collaboration with the Oklahoma Department of Insurance (OID) to create a single, statewide, automated provider directory.
- **Oklahoma providers who participate in a QHP** are asked to sign in to the portal and review pre-populated directory data and confirm or update their information.
- The goal is to gather input during the pilot phase with the objective of increasing data accuracy and exchange, and decreasing administrative burden to improve provider and patient experiences.

Issuers, including stand-alone dental plans in Oklahoma, are required to participate in the statewide directory pilot (Reference Bulletin No. 13-2023). CMS anticipates that participating issuers will use the updated and verified data from the portal to populate their own consumer-facing websites (consumers will not be able to access the CMS portal during the pilot phase).

What do I need to do as an Oklahoma provider?

- Providers who participate in a QHP in Oklahoma are encouraged to update their information in the portal, which can be accessed at Cms.Gov/QHPDirectoryPilot.

- Users are requested to sign in, review their pre-populated data, verify their information is accurate and complete or make corrections as necessary. Instructions and step-by-step guidance can be found in CMS's User Guide.

Why is CMS creating this directory?

- Provider directories are often inaccurate, and maintenance can be both costly and burdensome, requiring providers to routinely update directory information for multiple payers and plans.
- The goal of the pilot is to minimize the need for providers and healthcare organizations to update data in multiple locations, across multiple plans, while reducing the time issuers must spend requesting and tracking updates from network providers.
- Patients will also benefit from the ability to quickly access accurate provider information when seeking care.

Additional questions should be directed via email to QHPDirectoryPilot@cms.hhs.gov.

References:
CMS QHP Directory Pilot Fact Sheet
QHP Directory Pilot Frequently Asked Questions

Whitepaper: Don't underestimate younger generations' dental health decisions

There's a common misconception that younger generations, particularly Generation Z (18–27 years old) and millennials (28–43 years old), are less invested in their dental care compared to older generations. However, a recent Humana survey turns that thinking on its head. To learn more, please view our informative whitepaper.

Consider network status when making patient recommendations

As a provider, there may be times when you choose to recommend your patient(s) to other trusted professionals for follow-up treatment. Humana Dental does not require a formal referral process. However, please remind your patient(s) it is important that they confirm whether the provider you're recommending is **participating in the network for their plan**. If the provider is not in-network and they choose to seek treatment, it is advisable they confirm their out-of-network benefits prior to scheduling an appointment. This is important for all patients, but especially Humana members who may be on a Medicare Advantage (MA) plan and have a fixed or limited income.

Important plan information

Important 2026 CarePlus MA member ID card changes

In 2026, CarePlus providers should be aware of significant changes with the CarePlus MA member ID cards. **All CarePlus member ID cards will begin with the letter H as of Jan. 1, 2026.**

Additionally, all CarePlus MA members will receive a single member ID card containing the medical benefit on the front of the card and the dental benefit information on the back for 2026. A separate dental ID card will no longer be issued.

A summary of these changes as well as a sample ID card can be found below.

CarePlus MA member ID card changes for 2026

- All CarePlus MA member IDs will begin with the letter H as of Jan. 1, 2026.
  - For dates of service before and on Dec. 31, 2025, please bill your CarePlus-covered patient's current member ID. 2025 CarePlus MA member IDs begin with a number.
  - For dates of service on and after Jan. 1, 2026, please bill your CarePlus-covered patient's new member ID that begins with the letter H. If you bill using the legacy member ID that begins with a number, our system will be set up to crosswalk the legacy member ID with the new member ID, but it may delay your remittance and could make reconciliation difficult.
- Effective Jan. 1, 2026, CarePlus MA members will not receive a separate dental ID card. Beginning on Jan. 1, 2026, CarePlus MA members will use a single member ID card with the medical benefit on the front and dental benefit on the back. 2026 member ID cards are mailed starting Nov. 1, 2025.
  - The patient's dental plan number will be located on the back of their CarePlus member ID card and indicated with DENxxx. See the member ID card image below for reference (specific DEN number varies by plan).

Medicare Advantage benefit updates for 2026

Dental coverage on 100% of MA plans

- All Humana MA plans will cover 2 cleanings a year, plus exams and X-rays on 100% of MA plans nationwide.
  - Dental benefits for 2026 are available for review at **Humana.com/sb**. Providers are encouraged to visit the site to access the latest plans and coverage details.

Major services and periodontal scaling coverage

- 83% of patients will have embedded benefits that cover some major services. *
- 86% of patients will have plans that cover periodontal maintenance.

*Low coinsurance may apply to select major services depending on the patient's MA plan.
Please note: Some integrated Dual Special Needs Plans (DSNP) in Illinois, Indiana and Michigan include dental benefits that do not utilize the HumanaDental Medicare Network, specifically: DEN197, DEN198, and DENH54. For more information, please visit www.dentaquest.com/en/providers.

Additional benefit details are available on our dental resources page, in the Benefits section. To see the full list of MA plans, select the appropriate link to Review DEN codes. Additional dental benefit information can be accessed using the link to Find benefits resources.

Enhanced provider experience on Humana.com/SB
We encourage you to visit the newly updated **Humana.com/SB** site. The site has been improved with the provider's experience in mind, making it easier to quickly locate dental benefits for every dental plan.

FEDVIP plan information

For providers in network for our exclusive provider organization (EPO) Advantage Plus product, this also includes the Federal Advantage EPO plan. The Federal Advantage EPO plan has fixed member copayments for every covered procedure. Simply collect the listed copayment and submit a claim to Humana for reimbursement up to your Humana contracted Advantage EPO fees.

- Information about the calendar year EPO copay table and PPO schedule of benefits can be found on the dentist resources page and Federal Dental section.
- View the federal dental Frequently Asked Questions (FAQs) for more details and first-payer guidelines.

Oral cancer evaluations
The ADA's CDT codes below include an oral cancer evaluation as per the ADA's codes' descriptors:

- *D0120 Periodic oral evaluation – established patient*
- *D0150 Comprehensive oral evaluation – new or established patient* and
- *D0180 Comprehensive periodontal evaluation – new or established patient*

Oral cancer evaluations are crucial to detect cancerous growths in early, more treatable stages. According to the American Cancer Society, the overall lifetime risk of developing oral cavity and oropharyngeal cancer is about 1 in 59 for men and 1 in 139 for women.[1] An expert panel of the ADA's Council on Scientific Affairs and the Center for Evidence-Based Dentistry concluded it is good practice for clinicians to perform an intraoral and extraoral conventional visual and tactile examination in all adult patients to screen for oral cancer.[2] As a reminder, Humana's plans include routine oral cancer evaluations at comprehensive and periodic dental visits to ensure our members receive the recommended standard of care.

Antibiotic stewardship and prescribing practices
Humana is reminding providers of the importance of responsible antibiotic prescribing practices. Worldwide, dentists account for approximately 10% of antibiotic prescriptions, and studies have shown many of these antibiotic prescriptions were likely unnecessary.[3] The Centers for Disease Control and Prevention (CDC) estimates at least 30% of outpatient antibiotic prescriptions in the United States are unnecessary.[4] Overuse of antibiotics may lead to issues including antibiotic resistance (meaning that certain microbes may not respond to routine treatment efforts, potentially leading to additional treatment modalities), increased costs, and increased morbidity and mortality.[3,4]
Antibiotic resistance is recognized as a significant threat to public health and is expected to be responsible for 10 million deaths annually by 2050.[3] Observing responsible antibiotic prescribing practices can reduce the number of unnecessary prescriptions, minimizing the harm to individual

patients and the community as a whole.[4] Antibiotics should only be prescribed when needed and with the correct antibiotic, dosage and duration in accordance with evidence-based guidelines.[5]

References:

1. Oral Cavity & Oropharyngeal Cancer Key Statistics 2021 | American Cancer Society
2. Evidence-based clinical practice guideline for the evaluation of potentially malignant disorders in the oral cavity - The Journal of the American Dental Association
3. Preventing AMR and Infections | FDI World Dental Federation
4. Core Elements of Outpatient Antibiotic Stewardship | Antibiotic Prescribing and Use | CDC
5. Antibiotic Stewardship | American Dental Association

New group dental PPO plans in West Virginia

Humana Dental is pleased to announce group dental plans in West Virginia that launched in December 2025. The comprehensive dental portfolio includes Traditional Preferred, PPO and Preventive Plus plan options. Prospective members can learn more about plan details and eligibility here.

New PPO 155/844 Dental Plan launching in Minnesota

Beginning Feb. 1, 2026, Humana Dental is pleased to announce a new PPO 155/844 plan in Minnesota.

This PPO 155/844 plan meets requirements in Minnesota by offering:

- No waiting period on preventive services
- No more than 6-month waiting period on basic services
- No more than 9-month waiting period on major services
- Waiting periods remain consistent regardless of group size and late or timely applicants

Prospective members can visit dental insurance plans webpage to learn more about plan details and eligibility.

Creating efficiencies for your office

Importance of completing Treating Dentist field on dental claims

Accurate and complete claims submission is essential for timely reimbursement and proper documentation of dental services. Often confusion occurs around the distinction between the "Billing Dentist or Dental Entity" and the "Treating Dentist and Treatment Location Information" fields on the ADA Dental Claim Form. Ensuring both sections are completed correctly is not only required for all claims, but it also upholds the integrity of the claims process and supports compliance with regulatory standards.

Understanding the Difference

- Billing Dentist or Dental Entity: This section captures the individual dentist, group practice or corporation responsible for billing. It may include the owner of the practice, an administrative entity or another designated party who submits claims and receives payment for services rendered. The information here represents who is financially accountable for the claim.

- Treating Dentist and Treatment Location Information: This area requires details about the dentist or practitioner who performed the dental procedures, acting within the scope of their state licensure. It also specifies the exact location where the treatment took place. This is distinct from the billing provider and is crucial for accurate recordkeeping and compliance.

Why completing the Treating Dentist field matters

1. Regulatory compliance

   Dental claims must accurately reflect the provider who performed the care. CMS, state boards and other regulatory bodies require the treating provider's information to ensure the claim matches the practitioner's licensure and scope of practice. Omitting or inaccurately completing this field can result in claim denials, audits or even legal repercussions.
2. Transparency in care delivery

   Correctly identifying the treating dentist ensures patients, payers and oversight agencies know who provided the care. This transparency promotes trust and accountability, and it aids in resolving disputes or questions about the services rendered.
3. Accurate reimbursement

   Many payers require that the treating provider's details be present to process claims correctly. If this information is missing or incorrect, claims may be delayed, denied or returned for correction, impacting cash flow and administrative efficiency.
4. Credentialing and network requirements

   Some insurance plans and networks stipulate that only credentialed providers can render covered services. Listing the correct treating dentist ensures the claim complies with these requirements, protecting both the practice and the patient's benefits.
5. Audit and recordkeeping

   Proper documentation of who performed the treatment supports practices in responding to audits, reviews or patient inquiries. It provides a clear trail for verification and accountability.

Key takeaway

The "Treating Dentist and Treatment Location Information" section on the ADA Dental Claim Form must be completed for every claim, regardless of the billing arrangement. Even in group practices or corporate entities where the billing provider is different from the treating dentist, it is mandatory to accurately identify the dentist or practitioner who provided the care.

For further guidance, refer to the ADA Dental Claim Form Completion Instructions found here or view a sample claim form.

Completing both the billing and treating provider sections correctly streamlines claims processing, ensures regulatory compliance and supports the highest standards of patient care.

Benefits of using the most current ADA claim form

The ADA introduced an updated Dental Claim Form in 2024, which is designed to be more user friendly and streamline the process for submission and processing of dental claims. While Humana continues to accept any claim form, utilizing the most current form ensures efficient processing of your dental claims. Submitting outdated forms can potentially delay the process and how quickly you receive payment. The new form has enhanced data fields for electronic submission to facilitate faster claim processing.

Did you know?

Specialty referrals: Humana Dental products do not require referrals for specialist care.

Noncovered services: Prior to performing any noncovered services, please inform your members of any financial obligations.

Annual required surveys: Participating dentists must offer access to 24-hour emergency services.

- Network wait time surveys are conducted annually in select states to verify this requirement is upheld. Humana Dental appreciates your time and dedication in completing these surveys.
- In the event of an audit, Humana agrees any review it conducts will be to determine compliance with industry standard billing rules and practices, clinical appropriateness of covered services, applicable federal and state laws and applicable industry standards.

CAQH ProView can streamline credentialing and recredentialing

Humana understands how busy dental offices are, and we are here to help you simplify the credentialing and recredentialing process by sharing how to use **CAQH ProView**, the complimentary system Humana Dental uses to manage credentialing and recredentialing of our network providers. By submitting your provider's credentialing details in a single source for all healthcare organizations you partner with, it eliminates duplication, your providers' information is only shared with the organizations you choose and it is free.

Visit our Dental Provider Video Library and select the video **Simplify Credentialing with CAQH ProView** to learn more. You can find more helpful information about our credentialing process by visiting the join our dental provider network webpage.

Important: Please remember to keep CAQH updated. If your email is up to date in CAQH, you will receive reminders when it's time to re-attest or upload renewed documents.

Access your PPO fee schedule

Humana is pleased to share you can request your Humana PPO fee schedule anytime: day or night, through Humana's interactive voice response (IVR) platform. It is easy to request a copy of your fees, which Humana will fax to you by following the steps below.

Dental Health Maintenance Organization (DHMO) and EPO fees are not available through IVR. Dental providers who participate with Humana Dental through a rental network agreement will need to contact the rental network for a copy of their fee schedule.

To request your Humana PPO fees:

1. Call Humana's provider call center at 800-833-2223, Monday – Friday, 8 a.m. – 8 p.m., Eastern time, and say "fee schedule" when prompted.
2. You will be asked to enter your Tax Identification Number (TIN) and the provider's National Provider Identifier (NPI) for validation.
3. You will be asked to enter your fax number. Once the information is entered, your existing PPO fees will be faxed to you.

Availity Essentials – tips for using the provider portal

Important: Providers have several options to obtain member eligibility and claim information. If you experience issues with Availity Essentials™, you have other options so that patient care is not interrupted:

- Humana's automated phone system can provide 24-hour access to Humana member benefit and claims information. If you need to speak to a customer care agent please call 800-833-2223, during business hours, Monday – Friday, 8 a.m.– 8 p.m., Eastern time.
- Humana Customer Care cannot advise how to use or navigate to www.availity.com, but Availity Client Services (ACS) is available at 800-AVAILITY (282-4548), Monday – Friday, 8 a.m. – 8 p.m., Eastern time (excluding holidays), to assist with registration or navigation questions.
- Registered users can access the ACS Contact Support page to send an online message and create a ticket with the Availity Support team. Select Help & Training> Availity Support> Contact Support. If representatives are available to chat online, the "Start Chat" option will be blue.

Searching Humana Dental transactions

To be sure you receive accurate Humana Dental (or CompBenefits) member benefits, please select Humana Dental in the payer drop-down menu. Humana is the medical payer and, if selected, you may see a message that the member is not found. While dental care is a benefit option within medical, this relates only to oral surgery benefits.

Members with multiple coverages

It is important to receive accurate member benefit information, even when the member may not tell you they have additional coverage. When a member has multiple active dental plans, a message may appear indicating the selected patient has multiple plans and you need to select one from the drop-down menu to continue. As a best practice, the plan group number should be included when submitting the inquiry. When a member has dual coverage and the group number is not included, it can result in display issues on the benefit results page:

- When a member has multiple active plans under different ID numbers and the group number is not included, a display issue can result where both plans display, but there is a mismatch of the group number on the second plan returned.
- For a member who is a subscriber on one plan and a dependent on another, regardless of which ID number is entered, the results will only display plan details for one of the plans and no drop-down menu will appear.
    - This is important for providers who use their own practice management systems to view member eligibility and benefits information, as not including the Group ID can cause only one of the member's plans to be seen, regardless of which ID is used.

To ensure Eligibility & Benefit (E&B) results are accurate, it is important to change from the default search option under Patient Information to the fourth option that includes the group number:

- Proceed to the E&B Inquiry page, select your organization and payer (Humana Dental) and fill in the provider Information.
    - Proceed to the Patient Information section of the form. The default search option is

Patient ID, Date of Birth. In the drop-down menu, select the option for **Patient ID, Date of Birth, Group Number**.

- This results in a new 'Group Number' field displaying where the group number is entered.
- Continue filling out the remaining required fields on the form and submit. As a result, the accurate benefit information returns for the member ID and group number combination.

MA member IDs and claim status

To verify eligibility for a MA member, you should enter the ID number, also known as the "H" number, from the MA ID card on the E&B Inquiry page. Visit Humana MA Dental Benefits for Providers for more details about Medicare dental benefits and a sample image of a MA ID card.

You can quickly view a digital representation of a patient ID card (or proof of coverage) by signing in to www.availity.com and choosing the Humana Dental payer space. Next, on the Applications tab, select the "View ID Card" application. Select your organization in the drop-down, select Member ID as the Search Type, enter the member's ID number and click Search.

It is important to note the MA ID number will not work when searching for claim status results because the dental ID must be used. However, after entering the MA ID number on an E&B Inquiry, you will notice the dental eligibility results page shows the dental-specific ID number. This is the dental-specific ID number that can be used in a claim status search under the Claims & Payments menu.

Humana's proprietary Remittance Inquiry tool has been retired

Effective Sept. 20, 2025, Remittance Inquiry (Humana) has been fully retired. The previous landing page has been removed for a streamlined experience. Selecting Remittance Viewer from the Claims & Payments navigation now takes you directly to the viewer.

If you need help, please select the link to Watch a demo from the top right to learn more on how to use the Remittance Viewer. Please utilize the Give Feedback button if you have any comments or concerns to share.

Submit dental claims on Availity Essentials

Registered users can submit claims to Humana Dental via the Dental Claim tool. Please note that options for submitting predeterminations or adding attachments on dental claims are not yet available.

If you do not see the Dental Claim option, check with your Availity administrator to ensure you have the "Claim" role assigned to your profile. If you don't know who your administrator is, select your account name, then select My Account and Organizations from the left menu. From there, select Open My Administrators (next to Administrator Information).

The dental claim form is accessed by selecting the Claims & Payments menu. Under the Claims header, select Dental Claim, choose your organization, select dental claim under claim type, choose Humana Dental as the payer and select the Responsibility Sequence (Primary is the

default).

- Complete the fields in order from top to bottom. You have the option to print the claim entry before submitting. Once submitted, you can review and save the claim confirmation page if needed.
- Diagnosis codes are optional and generally used for medical claims. However, a diagnosis code may be required for treatment performed by an oral surgeon or if services were rendered because of an accident.
- "Remarks" is a field used only for information not captured within the existing fields on the ADA form. It is not a place to indicate a corrected claim. Corrected claims can be indicated by selecting Replacement of Prior Claim within the Ancillary Claim/Treatment Information option.

Visit Humana Dental providers resource page to learn How Availity Essentials supports your practice. Availity Client Services can be reached at 800-AVAILITY (282-4548) for questions on registration or other portal functionality.

Availity Essentials is a free multi-payer portal where you can use 1 user ID and password to work with Humana Dental and other payers in your state. There is no cost to register and Availity is compliant with all Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Administrators are responsible for setting up organization accounts and assigning roles to users in their office(s). To work with Humana Dental on Availity Essentials, your organization must have an Availity account.

Compliance corner

New CMS requirement for Medicare predeterminations in effect as of Jan. 1, 2026

As of Jan. 1, 2026, the federal CMS Final Rule 0057-F **requires** all Medicare predeterminations to be completed **within 7 calendar days** for standard (nonurgent) dental services. Note: this is a time frame requirement and not a requirement that providers must submit a predetermination. This ruling emphasizes the need to improve interoperability, (the ability of different health information systems to securely access and exchange health data for more coordinated patient care), with a goal to reduce burden on patients, providers and payers to effectively help lower healthcare costs. To meet the streamlined time frame:

Humana must receive supporting clinical information at the time of submission on predetermination requests for dental services.

Best practices:
For the most efficient claims processing, please submit different pretreatment plans **separately**.

- Example: If submitting to determine coverage for a bridge versus coverage for an implant, sending separate pretreatment plans can decrease the chance of delay due to conflicting services being submitted on the same tooth or arch.
- Please remember to verify patient's benefit coverage in Availity Essentials using the Humana Dental payer.

When submitting a predetermination, your treatment plan should include:

- ✓ A list of ADA nomenclature and codes
- ✓ Your written description of the proposed treatment
- ✓ Supporting pretreatment X-rays or other required diagnostics (please reference Humana claims attachment guidelines
- ✓ Itemized cost of the proposed treatment
- ✓ Any other diagnostic materials Humana Dental requests

For guidance on required clinical information and required pretreatment X-rays, please visit our dentist resources webpage, scroll down to the section for Guides, and review the list of Humana claims attachment guidelines. You can access these guidelines and those of other dental benefit plans in 1 central location by enrolling with Vyne Fastlook. To learn more, visit Vyne Dental. For DentalXchange, visit dentalxchange.com/solutions/for-providers.

Importance of notifying Humana about changes

Humana makes every attempt to maintain accurate directories so our members can find your practice. Per CMS guidelines, we only list providers at locations with routine office hours and Humana makes quarterly outreaches to verify our directory data is current. State legislation trends increasingly require prompt and accurate directory information, highlighting the importance of timely updates. Humana may also reach out to your office if we haven't received claims from you recently, to ensure we have the most up-to-date information.

If any changes impact your office, please notify us as soon as possible. If you are contracted through our rental network partners, please notify the applicable rental network promptly, so Humana can receive the update in a timely manner.

You play a key role in helping us keep our directory current. Please notify Humana promptly when updates are needed to your practice information, and remember to include all relevant data for efficient processing:

- Change in location (adding, closing or changing offices)
- Updates to phone/fax number, email and/or web address (if available)
- Changes to your practice's TIN or ownership changes
- Whether your providers' accepting new patients status has changed
- Changes to a treating provider's license or NPI, name, specialty, board certifications, cultural competency training, spoken languages (if applicable), etc.

There are several ways to send us your information:

You can quickly and easily send us updates using our custom application on www.availity.com. To do so, sign in to your account, choose the Humana Dental payer space, and select the **Dental Provider Directory** app.

- Select your organization and TIN from the drop-down menus.
- Enter the provider name.
- In the box labeled Current Directory Data, please tell us the directory listing that needs updating.
- Finally, in the box labeled Correct Directory Data, indicate the correct information and then press submit.

On Humana's online directory please locate your dental provider's listing by entering a ZIP code under Search as a guest and select "Get started." Select the Dental button and choose the appropriate plan (such as PPO). Then choose the network (such as PPO/Traditional Preferred). Here you can search by provider name, or if you prefer to search by NPI instead, select the "More" drop-down and choose the NPI filter.

- Once you locate the provider and office, if any changes are needed, you can easily notify us through the link to **Report incorrect information.**
  - Choose from the reasons listed and select "Submit" to send us the feedback.

Participating providers can email their dental single point of contact (SPOC) directly or contact the dental service team directly at dentalservice@humana.com.

If mailing by United States Postal Service (USPS) is preferred, the mailing address is:

Humana c/o Dental Service
1100 Employers Blvd.
Green Bay, WI 54344

Cultural Competency training for Medicare providers

Humana Dental providers who serve our Humana Medicare members may choose to complete Cultural Competency training. CMS requires Humana to display this detail when a provider has told us they've completed the Cultural Competency training.

Meeting the requirement indicates you understand cultural differences and health equity disparities in the populations you work with. It means being knowledgeable about how to work with patients from varying cultural and economic backgrounds and being sensitive to clinical challenges that may contribute to their reasoning for seeking treatment or guidance. Additionally, it suggests being able to recognize cultural biases and misconceptions, so they don't interfere with the expert care you provide your patients.

The key objectives of Cultural Competency training are to:

- Define cultural humility, health equity and implicit bias
- Recognize personal and systemic hidden preferences and biases; understand the effects of power and privilege on staff interactions and how these impact patient care delivery
- Identify and apply skills to evaluate methods for mitigating health inequities and implicit bias

If a provider(s) in your office has completed this training, you can let us know to update their listing in our directory to reflect this. Participating providers may notify us by sending an email to dentalservice@humana.com with the provider's name and NPI number.

While work is underway to incorporate cultural competency training into the Humana Dental payer space of www.availity.com, if you are contracted to provide services for a Humana Medicare member, you may access the Humana Medicare Cultural Competency Training, which currently resides on the medical payer space of Availity.com. For more information, please see Compliance Training Materials for Providers and the section for Cultural Competency Training for Medicare providers.

Utilizing the KX modifier on claims for dental services

Effective July 1, 2025, providers are required to include the KX modifier **along with a diagnosis code** on a claim when they believe the dental service is medically necessary and include

appropriate documentation to support/ justify the medical necessity of the service; coordination of care between medical and dental practitioners must occur.

Humana recommends submitting dental procedures (coverable under the basic medical benefit) as a predetermination for Medicare HMO or PPO plans or an Advance Coverage Determination (ACD) for Medicare private fee-for-service plans. Important: claims submitted with the KX modifier, but no ICD code will result in a denial. The ICD code is required when the KX modifier is noted on the dental claim and required to be able to route the claim to the medical plan for consideration.

Refer to the **Medicare Basic Dental Benefit Exceptions Guidelines** for more details including page 34 regarding the submission of an ACD/predetermination for dental services inextricably linked to a covered medical procedure or condition. Note: **Claims for Humana MA patients** – please find the claims address and general claims and payment information, including the appropriate claim forms on page 35.

- CMS implemented guidance in July 2024 regarding submission of claims for dental services inextricably linked to a covered medical procedure or condition. Payment under Medicare Parts A and B may be made for dental services that are inextricably linked to, substantially related and integral to the clinical success of, a certain covered medical service.
- The KX modifier for dental services indicates that the service is "medically necessary" and "inextricably linked" to a covered medical procedure, requiring documentation to prove this linkage. To use it, dentists must coordinate care with the patient's physician, submit supporting documentation to demonstrate medical necessity, and include a valid ICD-10 diagnosis code on the claim form.
- CMS provided examples where dental and medical services are inextricably linked and codified such examples under subsection (§) 411.15(i)(3) [see (i) Dental services- and (3) Inapplicability]. These are examples of circumstances where CMS believes there is a clear inextricable link between dental and medical services, but it is not an exhaustive list of instances where dental and medical services are inextricably linked.

Have questions?

How to reach the Humana provider call center

You can reach Humana Dental/Medicare Dental at 800-833-2223, Monday – Friday, 8 a.m. – 8 p.m., Eastern time. Humana's automated customer care line provides claim and patient information. When calling, please have the following information handy:

- TIN
- Patient's name and date of birth
- Patient's Humana member ID number
- Date(s) of service

Helpful links

- Dental Provider Manual
- Medicare Dental Office Handbook 2026

- Dental Resources for Providers

Humana Dental Highlights is a quarterly publication for dental providers throughout the Humana network.