Humana
Healthy Horizons®
in Virginia

Humana Healthy Horizons in Virginia Prior Authorization and Notification List and Virginia Long-Term Services and Supports Prior Authorization and Notification List

View the Humana Healthy Horizons® in Virginia prior authorization and notification List (PAL).

After reading the applicability of the prior authorization requirements below, access services, codes and medication by selecting the appropriate link:

View the Humana Healthy Horizons professionally administered drug prior authorization list.

View the Humana Healthy Horizons long-term services and supports (LTSS) PAL.

Please note the term prior authorization (also known as preauthorization, precertification or preadmission), when used in this communication, is defined as a process through which the healthcare provider is required to obtain advance approval from Humana Healthy Horizons as to whether an item or service will be covered.

Notification refers to the process by which the healthcare provider notifies Humana Healthy Horizons of the intent to provide an item or service. Humana Healthy Horizons requests notification as it helps coordinate care for members. This process is distinguished from prior authorization. Humana Healthy Horizons does not issue approval or denial for notifications.

Investigational and experimental procedures usually are not covered benefits. Please contact Humana Healthy Horizons for confirmation of coverage.

Important notes:

- For any service or supply exceeding Virginia Department of Medical Assistance Services (DMAS) limits, prior authorization is required.
    - Please visit the DMAS Durable Medical Equipment (DME) website to determine limits.
- Chiropractic services are not covered by the DMAS for members over the age of 21 unless they are enrolled in the Family Access to Medical Insurance Security—MOMS (FAMIS MOMS) programs.

Please note: Urgent/emergent services do not require referrals or prior authorization.

Failure to obtain prior authorization for a service could result in financial penalties for the provider and reduced benefits for the member. Services or medications provided without prior authorization may be subject to retrospective medical necessity review. Humana Healthy Horizons recommends individual providers making specific requests for services or

medications verify benefits and prior authorization requirements with Humana Healthy Horizons prior to providing services.

Information required for a prior authorization request or notification may include the following:

- Member's name, Medicaid ID and date of birth
- Date of service or hospital admission
- Procedure codes, up to 10 maximum per authorization request or notification
- Date of proposed procedure, if applicable
- Diagnosis codes (primary and secondary), up to 6 maximum per authorization request or notification
- Service location
- Inpatient location (e.g., acute hospital, skilled nursing, hospice)
- Outpatient location (e.g., telehealth, office, home, off-campus outpatient hospital, on-campus outpatient hospital, ambulatory surgery center)
- Referral (e.g., office, off-campus outpatient hospital, on-campus outpatient hospital, ambulatory surgery center, other)
- Tax Identification Number (TIN) and National Provider Identifier (NPI) of treatment facility where service is rendered
- TIN and NPI of the provider performing the service
- Caller's/requestor's name and telephone number
- Attending provider's telephone number
- Relevant clinical information
- Discharge plans

Submitting all relevant clinical information at the time of the request will help expedite determination. If additional clinical information is required, a Humana Healthy Horizons representative will request the specific information needed to complete the authorization process.

How to request prior authorization for medical and behavioral health services:

- Except where otherwise noted, healthcare providers can request prior authorization through Availity Essentials™.
    - If you have registration issues, call Availity Client Services at 800-AVAILITY (282-4548), Monday – Friday, 8 a.m. – 8 p.m., Eastern time.
- For medical prior authorization, healthcare providers can request prior authorization from the Humana Healthy Horizons Clinical Intake team by faxing 931-650-3709.
- For behavioral health prior authorization, healthcare providers can request prior authorization from the Humana Healthy Horizons Clinical Intake team by faxing 931-650-3707.
- If you have questions, call the Humana Healthy Horizons Customer Care Service department at 844-881-4482, Monday – Friday, 7 a.m. – 7 p.m., Eastern time.

How to request LTSS prior authorization:

- Healthcare providers can fax 502-508-1607.
- Providers can send an email on behalf of the member to VAMCDLTSSUtilizationManagement@humana.com.
    - Please include the member's name, member Medicaid ID number and phone number in addition to the prior authorization request.

How to request prior authorization for professionally administered drugs:
Humana Healthy Horizons handles all prior authorization requests for medications typically received as an injection at a healthcare provider's office. You can initiate prior authorization by:

- Submitting your request online at CoverMyMeds®
- Faxing requests to 888-447-3430
    - Request forms can be found by visiting Humana's Prior authorization for professionally administered drugs webpage.
- Calling 866-461-7273, Monday – Friday, 8 a.m. – 11 p.m., Eastern time

How to request dental prior authorization:

- Healthcare providers can request prior authorization by visiting the DentaQuest® website.
- Providers can request dental prior authorization by calling Cardinal Care Smiles at 888-912-3456, Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

How to request vision prior authorization:

- Healthcare providers can request prior authorization by visiting the EyeMed® webpage.
- Providers can call Humana Healthy Horizons at 844-881-4482, Monday – Friday, 8 a.m. – 11 p.m., Eastern time.

This list is subject to change with notification. However, this list may be modified throughout the year for additions of new-to-market medications or step-therapy requirements for medications without notification via U.S. Postal Service mail.