Humana
Healthy Horizons®
in Kentucky

Provider Orientation and Training

Information for Medicaid Healthcare Providers and Administrators

2023

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

Humana®

118806KY1122 (HUMP103201) KYHLSMWEN

Training topics

Topic	General guidance	Page
Enrollee Eligibility	• Humana Healthy Horizons in Kentucky-issued enrollee ID cards • Eligible populations • Verifying eligibility • Primary care provider (PCP) assignment • Medicaid redetermination process	5
Covered Services	• Covered services • Early and Periodic Screening, Diagnosis and Treatment (EPSDT) • Substance-use disorder identification and referrals • Pharmacy • Telehealth • Urine drug testing	15
Humana Healthy Horizons in Kentucky's Added Benefits	• Description of added services	27
Provider Services	• Provider rights and responsibilities • Credentialing • Provider status changes • Provider relations	32

Training topics are based on the following:

- Humana's contract with the Kentucky Department of Medicaid Services (DMS)
- Humana's policies and procedures

Training topics (cont'd.)

Topic	General guidance	Page
Clinical	• Referrals • Prior authorization requirements and process • Retrospective reviews • Preventive health services and clinical practice guidelines • Access to care requirements • PCP after-hours availability • Enrollees with special healthcare needs • Transitioning during pregnancy • Care management overview and functions • Population health management • Chronic condition management • Enrollee incentive programs • Maternal and transition programs • Interpretation/translation services • Advance directives • Enrollee medical record reviews • Reporting communicable diseases	38
Claims Processing and Claims Resolution Process	• Electronic and paper claim submissions • Timeliness requirements • Online resource for claim status and edit questions • Electronic claims payment option • Balance billing	79

Training topics (cont'd.)

Topic	General guidance	Page
Electronic Health Records (EHR)	• Advantages of EHR • EHR Incentive Program	89
Provider Grievance and Appeals	• Grievances • Appeals and expedited appeals • Submitting to Kentucky DMS • Claim dispute process	93
Utilization Management	• Health services and utilization management • Discharge support	100
Quality	• Quality improvement requirements • External quality review organization	104
Marketing Guidelines	• General guidelines	110
PCP Quality Recognition Program	• Information regarding the PCP value-based recognition program	112
Provider Training Requirements	• List of trainings, where to find them and how to assure completion is documented	115
Fraud, Waste and Abuse	• Requirement to report, reporting options and protections related to reports of suspected false claims	117
Humana Websites and Numbers	• Helpful web addresses • Contact phone numbers	121

Enrollee Eligibility

Enrollee eligibility

- Medicaid eligibility is determined by the Kentucky Department for Community Based Services (DCBS) in the county where the consumer resides.
- Eligibility begins on the first day of each calendar month, including the initial application month, with two exceptions:
  - Newborns, born to an eligible mother, are eligible at birth.
    - The delivery hospital is required to enter the birth record in the Kentucky Certificate of Live Birth, Hearing, Immunization and Lab Data (i.e., KY CHILD) birth record system. The delivery hospital is required to use this information to auto-enroll eligible newborns within 24 hours of birth. All claims for newborns must be submitted using the newborn's Humana Healthy Horizons in Kentucky and Kentucky Medicaid ID numbers.
    - When the mother is enrolled in Humana Healthy Horizons, newborn coverage begins on the date of birth. The newborn appears on the primary care provider’s (PCP) enrollee eligibility list after Humana Healthy Horizons adds the newborn to its system.
  - Consumers who meet the definition of unemployed in accordance with federal regulation 45 CFR 233.100 are eligible on the date they are deemed unemployed.

Populations served – enrollee eligibility

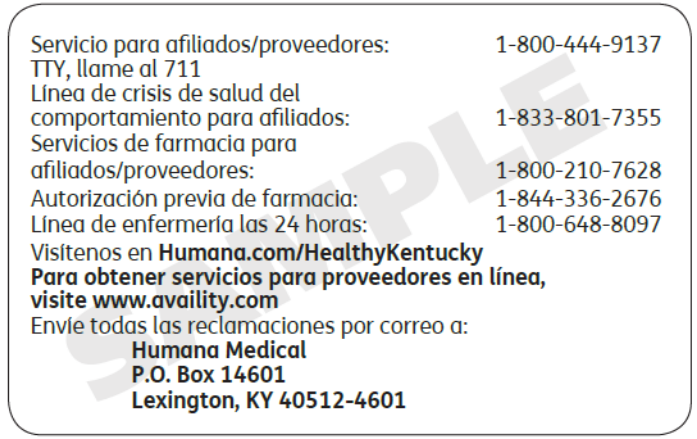
Kentucky Medicaid and the Children's Health Insurance Program (i.e., CHIP) provide healthcare coverage to low-income children, pregnant women, adults, seniors and people with disabilities in the Commonwealth of Kentucky.

Enrollees are eligible to receive Medicaid assistance under one of the following aid categories:

- Temporary Assistance to Needy Families
- Children and family related
- Aged, blind and disabled—Medicaid only
- Pass-through
- Poverty level pregnant women and children, including presumptive eligibility
- Aged, blind and disabled receiving state supplementation
- Aged, blind and disabled receiving Supplemental Security Income (SSI)
- Younger than 21 and in an inpatient psychiatric facility
- Children younger than 18 who receive adoption assistance and have special needs
- Dual-eligible enrollees
- Disabled children
- Adults ages 19 to 64 with income less than 138% of the federal poverty level

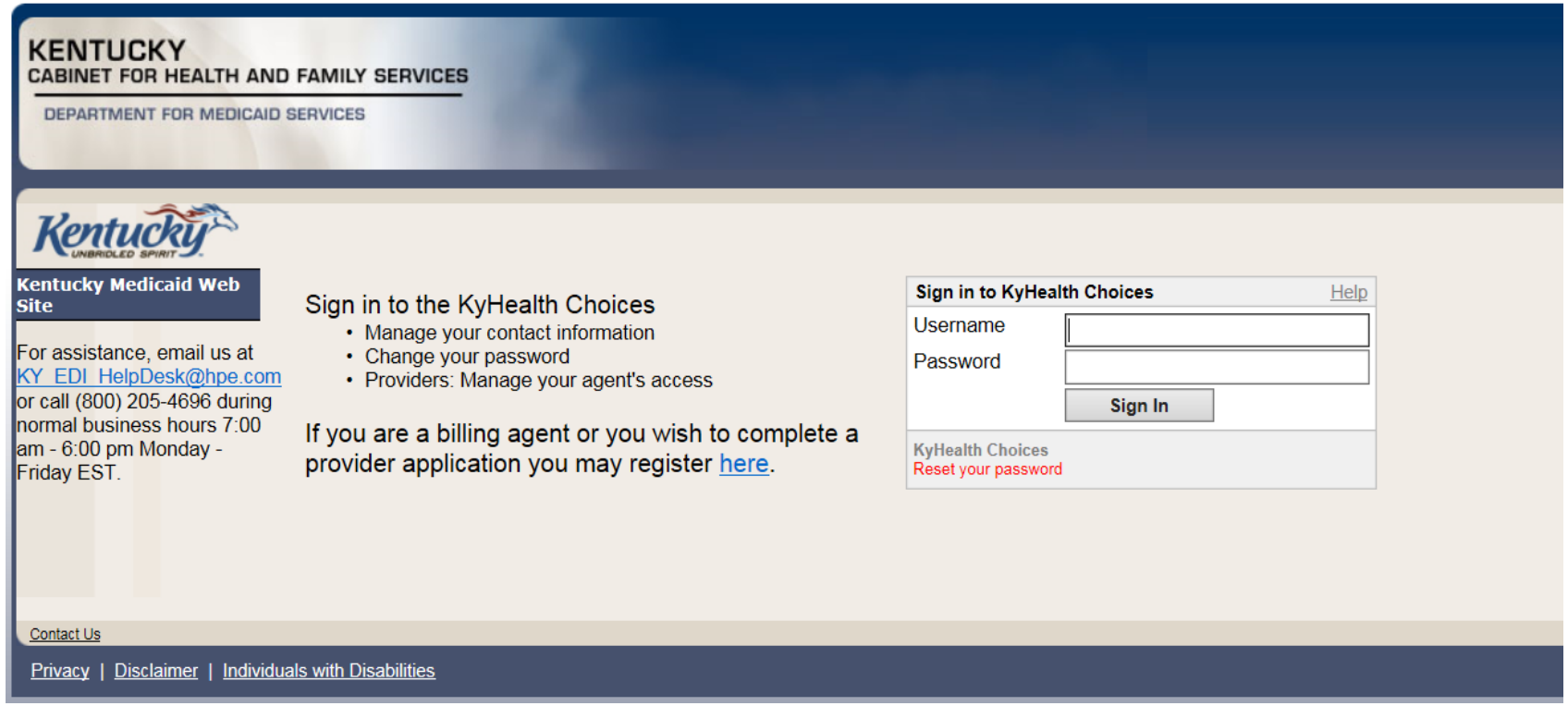
Enrollee eligibility – Identification (ID) cards

- All Humana Healthy Horizons in Kentucky enrollees receive an identification card.



Enrollee eligibility (cont'd.)

- Before providing any services (except emergency services), healthcare providers should verify enrollee eligibility via the HealthNet portal.
- To access HealthNet, please visit kymmis.com/kymmis/index.aspx



Primary Care Provider (PCP) assignment

Enrollees may select a PCP at the time of enrollment with Kentucky DMS. For enrollees who do not select a PCP at the time of enrollment, Humana Healthy Horizons automatically assigns a PCP based on the following criteria:

- Enrollee is assigned previous PCP if that PCP participates with Humana Healthy Horizons' PCP panel.
- Selection of PCP is based on family relationships.
- Geographic assignment is used when an enrollee has no record of past PCP relationships within the participating Humana Healthy Horizons PCP panel.

Enrollees have the option to change participating PCPs as often as needed. Enrollees can initiate a change in PCP by calling Enrollee Services. PCP changes are effective on the first day of the month following the change request.

Humana Healthy Horizons monitors enrollees' claim history and utilization and may periodically update PCP assignments of enrollees when a patient relationship with a PCP other than the one assigned is evident.

Involuntary dismissal from PCP practice

There may be instances in which an enrollee is not a good match for a PCP, or an enrollee might be living through circumstances that make it difficult to abide by established provider-patient protocols.

PCPs have the right to request an enrollee's disenrollment from their practice and reassignment of the enrollee to a new PCP under the following circumstances:

- Incompatibility of the PCP/patient relationship
- Enrollee has not utilized service(s) within one year of enrollment into the PCP's practice and the PCP documented unsuccessful contact attempts by mail and phone on at least six separate occasions during the year
- Inability to meet the medical needs of the enrollee

For a list of the requirements needed for each of these, please consult the Provider Manual online at Humana.com/HealthyKY.

Involuntary dismissal from PCP practice (con't.)

Once the PCP office attempts the required communications and outreach, the PCP office may initiate issuance of the involuntary dismissal notice. The PCP can initiate dismissal procedures by:

- Notifying the enrollee of dismissal by certified letter, which must include the following details:
  - He or she must contact Humana Healthy Horizons in Kentucky enrollee services to choose another PCP.
  - Reason for dismissal is requested.
- Mailing or faxing a copy of the letter to Humana Healthy Horizons as noted below:

Humana Provider Relations
Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax: 800-949-2961

After receipt of notice, Humana's provider relations team reviews the notice to ensure the provider met all criteria to request dismissal. Humana then notifies the PCP with the determination and, if necessary, notifies the PCP of any further action to take. The dismissing PCP must continue to serve the affected patient until a new PCP is assigned.

Medicaid redetermination process

<Please note: Due to the ongoing COVID-19 Public Health Emergency, the process described below is currently on hold.>

Humana Healthy Horizons enrollees must complete the Medicaid eligibility redetermination process to ensure they don’t lose their Medicaid coverage and benefits.

- The DCBS sends enrollees a form by mail when it is time to initiate the redetermination process.
- Humana Healthy Horizons also reminds enrollees to complete the redetermination process or risk losing their coverage and benefits.
- If a Humana Healthy Horizons-covered patient asks about completing the redetermination process, please advise that it is required to maintain Medicaid coverage.

Medicaid redetermination process

Enrollees can complete the process in one of four ways:

Online

Enrollees who applied for Medicaid online should visit the self-service portal at www.kynect.ky.gov to complete the redetermination process.

By mail

Enrollees can mail a completed **Renewal Form for Medical Coverage** (sent to Medicaid recipients in Kentucky) to:

DCBS Family Support
P.O. Box 2104
Frankfort, KY 40602

By phone

Call 855-306-8959

In person

Enrollee can visit their local DCBS county office.

Office locations are available online at the DCBS website.

Covered Services

Covered services

Humana Healthy Horizons in Kentucky, through its contracted healthcare providers, is required to arrange for the following medically necessary services for each patient:

Alternative birthing center services	Hearing services, adult hearing aids
Ambulatory surgical center services	Home health services
Behavioral health services—mental health and substance-use disorders	Hospice services (non-institutional only)
Chiropractic services	Independent laboratory services
Community mental health center services	Inpatient hospital services
Dental, adult second dental cleaning, dentures, implants, root canals, extractions, restoration and periodontics	Inpatient mental health services
Durable medical equipment, including prosthetic and orthotic devices and disposable medical supplies	Meals and lodging for appropriate escort of enrollees
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening and special services	Medical detoxification, meaning management of symptoms during the acute withdrawal phrase from a substance to which the individual has been addicted
End-stage renal dialysis services	Medical services including, but not limited to, those provided by physicians, advanced-practice registered nurses, physician assistants, federally qualified health centers (FQHCs), primary care centers and rural health clinics
Family planning services in accordance with federal and state law and judicial opinion	Medications administered in an office, clinic, hospital or home setting

Covered services (cont'd.)

Organ transplant services not considered investigational by the Food and Drug Administration (FDA)	Specialized children's services clinics
Other laboratory and X-ray services	Targeted case management
Outpatient hospital services	Therapeutic evaluation and treatment, including physical therapy, speech therapy, occupational therapy
Outpatient mental health services	Transportation to covered services, including emergency and ambulance stretcher services
Pharmacy and limited over-the-counter drugs including mental/behavioral health drugs	Urgent and emergency care services
Podiatry services	Vision, adult glasses and contacts
Preventive health services, including those currently provided in public health departments, FQHCs/primary care centers and rural health clinics	Specialized care management services for enrollees with complex chronic illnesses (includes adult- and child-targeted case management)
Psychiatric residential treatment facilities (Level I and Level II)	

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

- Children (birth through 18) and adults (19 through the end of the 21st birthday month) eligible for Medicaid's EPSDT program continue to receive vision and dental coverage through EPSDT coverage. More information is available is available online.
- PCPs are encouraged to enroll in the Department for Public Health and Department for Medicaid Services Vaccines for Children Program, which offers certain vaccines free of charge to Medicaid enrollees younger than 21. For more information, please visit the Kentucky DMS Vaccines for Children website.
- The Kentucky Medicaid Department for Public Health Childhood Lead Poisoning Prevention Program requires children receive a blood-lead level test at ages 12 and 24 months. Federal regulation requires that all children receive a blood test for lead at:
  - 12 months and 24 months
  - 24 months and 72 months for children who have not had a previous blood lead screening

EPSDT special services

EPSDT special services include coverage for other medically necessary healthcare, evaluation, diagnostic services, preventive services, rehabilitative services and treatment or other measures not covered under Kentucky Medicaid, including:

- Preventive, diagnostic or rehabilitative treatment or services that are medically necessary to correct or ameliorate the individual's physical, developmental or behavioral condition

Medically necessary services are available regardless whether those services are covered by Kentucky Medicaid:

- Medical necessity is determined on a case-by-case basis.
- EPSDT special services subject to medical necessity often require prior authorization.
- Consideration must be given to the child's long-term needs and all aspects of the child's needs, such as physical, developmental, behavioral, etc.

Behavioral health

PCPs are required by Kentucky DMS to employ screening and evaluation procedures for the identification of behavioral health or substance-use conditions in their patients. Referral to appropriate behavioral health specialists is an expected standard of care.

Trainings are available to integrate behavioral health care into PCP practices, including interventions and screenings. Educational sessions on prevalent mental health and substance-use disorder diagnosis are available to Humana Healthy Horizons-enrolled providers through Relias at Humana.com. Providers may enroll in these courses at a time that is convenient for them.

Substance-use disorder identification and referrals

Providers are encouraged to follow Screening, Brief Intervention and Referral to Treatment (SBIRT) best practices for all enrollees who may be affected by a substance-use disorder.

For additional training on how to use SBIRT in your practice, please visit the Substance Abuse and Mental Health Services Administration (SAMHSA).

To refer a patient for substance-use disorder residential treatment, please visit this website to view real-time admission availability.

Please note: Exceptions to this policy apply to enrollees eligible for participation in the Lock-in Program.

Urine drug testing

Humana Healthy Horizons implemented the Kentucky DMS Urine Drug Testing (UDT) policy, effective July 1, 2020. UDT claims are now processed for payment as indicated by the department's policy, per the provider's Humana contract agreement and/or the Humana out-of-network payment policy.

Once the enrollee exceeds the benefit limit as established by the department, Humana denies the claim. Providers may appeal a claim denial. Humana Healthy Horizons recommends that providers submit medical records as supporting documentation to prove the medical necessity for the service with the appeal request. Additionally, claims paid for UDT services that exceed the enrollee's benefit are reviewed for recovery. Humana Healthy Horizons recommends that providers submit medical records as supporting documentation to support the medical necessity for the service when disputing an overpayment recovery.

If a provider does not agree with the decision on a processed claim, the provider has 60 calendar days from the date of the original claim submission denial to file an appeal. For more information on appeals, please refer to the Provider Grievance and Appeals section.

For the full Humana Healthy Horizons' UDT policy, please view the UDT policy update notification.
For the Kentucky DMS UDT policy, please view this update.

Kentucky Medicaid pharmacy benefit

- All Kentucky Medicaid managed care organizations (MCOs), including Humana Healthy Horizons, use pharmacy benefit manager (PBM) MedImpact for all pharmacy claims processing and pharmacy prior authorizations (PA).

- All outpatient drugs, including over-the-counter (OTC) drugs, are covered under a single Kentucky formulary and preferred drug list (PDL) managed by MedImpact. This does not include physician-administered drugs, which continue to be managed by MCOs under their medical benefit.

- Please visit Kentucky.magellanmedicaid.com for a list of preferred drugs covered under the Kentucky PDL.

Kentucky Medicaid pharmacy benefit (cont'd.)

All prior authorizations are managed by MedImpact.

- The Kentucky DMS-approved MedImpact Universal PA Form is posted on the MedImpact Single PBM website.
- Please call 844-336-2676 or fax all pharmacy PA requests to 858-357-2612.
- You also may submit your request online through Cover My Meds, Surescripts or CenterX ePA portals.

Prior authorization for medications administered in medical office

For drugs delivered/administered in physician's office, clinic, outpatient or home setting (fee-for-service providers only):

- Obtain forms at Humana.com/medPA.
- Submit request by fax to 888-447-3430.
- View preauthorization and notification lists at Humana.com/PAL.

Telehealth – Urgent care services

Virtual Urgent Care Services – MDLive (Telehealth)

Humana Healthy Horizons enrollees can connect with a board-certified doctor for virtual urgent care (i.e., telehealth visit). All virtual visits are available on demand 365 days per year, 24 hours per day or by scheduled appointment with MDLive. Visits are convenient, private and secure via mobile app, video or phone. Virtual visits avoid high-cost ERs and urgent care facilities. All prescriptions can be sent directly to a local pharmacy if medically necessary.

MDLive scope of services:

- 24/7 urgent care services for nonemergency needs
- Medical evaluation and management
- Virtual urgent care common conditions treated: minor headache, minor sprain, nausea, vomiting, diarrhea, bumps, scrapes, cough, sore throat, congestion and respiratory issues

Provider types (all board-certified):

- Internal medicine
- Family practice

Humana Healthy Horizons in Kentucky's Added Benefits

Added benefits

Humana Healthy Horizons in Kentucky offers enrollees extra benefits, tools and services, at no cost to the enrollee, that are not otherwise covered or that exceed limits outlined in the Kentucky State Plan and the Kentucky Medicaid Fee Schedules. The following are examples of value-added services (VAS); for a full listing, please consult the provider manual.

VAS	Details and limitations
Doula services *	Doula assistance for pregnant females to provide emotional and physical support to the laboring mother and her family, four prenatal visits, four postpartum visits and one visit for delivery assistance per pregnancy.
Sports physical *	One sports physical per year for enrollees 6 to 18.

*Humana Healthy Horizons will publish billing guidelines on Humana.com/HealthyKY for services indicated above with an asterisk.

Added benefits (cont'd.)

Go365 for Humana Healthy Horizons in Kentucky is a wellness program that offers enrollees the opportunity to earn rewards for taking healthy actions. Most are awarded based on Humana's receipt of the provider's claim services rendered. **Humana Healthy Horizons in Kentucky recommends that all providers submit their claims on behalf of an enrollee by the end of February 2024.** This allows the enrollee time to redeem their rewards. Go365 is available to all enrollees who meet the requirements of the program. Rewards are not used to direct the enrollee to select a specific provider.

Healthy behavior rewards	Details and limitations
Breast cancer screening	$25 in rewards (one per year) for female enrollees 50 and older who receive a mammogram.
Cervical cancer screening	$25 in rewards (one per year) for female enrollees 21 and older who receive a Pap test.
Colorectal cancer screening	$25 in rewards (one per year) for enrollees 45 and older who obtain a colorectal cancer screening as recommended by their PCP.
COVID-19 vaccinations	$40 in rewards (once per year) for enrollees who upload a picture/file of their completed COVID-19 vaccine card. Enrollees who were vaccinated prior to enrollment in Humana plan may upload vaccination card within 90 days of enrollment to receive the reward. New enrollees who were not vaccinated prior to enrollment in Humana have 90 days from completion of the vaccination to upload the vaccination card to receive the reward. (Eligible ages per CDC.)
Diabetic retinal exam	$40 in rewards (one per year) for diabetic enrollees 18 and older who complete a retinal eye exam.
Diabetic screening	$20 in rewards (one per year) for diabetic enrollees 18 and older who complete an annual screening with their primary care provider for HbA1c.
Pediatric dental visits	$30 in rewards for enrollees 2 to 20 who complete one dental cleaning per year.
Flu vaccine	$30 in rewards for enrollees from birth to 2 years old who receive an annual flu vaccine from their provider, pharmacy or self-reporting if they received a vaccine from another source. $20 in rewards for enrollees 3 and older who receive an annual flu vaccine from their provider, pharmacy or self-reporting if they received a vaccine from another source.
Follow-up after high-intensity care for substance use disorder	$25 in rewards for enrollees who received follow-up care within 30 days of an inpatient hospital discharge, residential treatment or detoxification visit for a diagnosis of substance use disorder.
Follow-up after hospitalization for mental illness	$25 in rewards for enrollees who received follow-up care within 30 days after a hospital discharge for a diagnosis of select mental illness or intentional self-harm.

Rewards are non-transferrable to other managed care plans or other programs. Rewards have no cash value. E-gift cards may not be used for tobacco, alcohol, firearms, lottery tickets and other items that do not support a healthy lifestyle.

Added benefits (cont'd.)

Healthy behavior rewards	Details and limitations
Haircuts for Kids	One standard haircut for enrollees in grades K-12, valued at $15-$20, who upload a photo of their school registration form, school ID or class schedule (Redemption period March 2023 through April 2023). One standard haircut for enrollees in grades K-12, valued at $20, who upload a photo of their school registration form, school ID or class schedule, redemption period July 2023 through September 2023.
Health risk assessment (HRA)	$20 in rewards for enrollees who complete their health risk assessment (HRA) within 30 days of enrollment with Humana; one reward per lifetime.
Human papillomavirus (HPV) vaccine	$50 in rewards (once per lifetime) for enrollees who receive two doses of the HPV vaccine between their 9th and 13th birthday.
HumanaBeginnings™ program	$15 in rewards, per pregnancy, for pregnant females who enroll and complete the HumanaBeginnings Care Management program.
Level of care education	$10 in rewards (once per year) for enrollees 19 and older who complete education for when to access the emergency room.
Postpartum visit	$30 in rewards (once per pregnancy) for postpartum females who complete one postpartum visit within 7 to 84 days after delivery.
Prenatal visit	$30 in rewards (once per pregnancy) for enrollees all pregnant females who complete one prenatal visit within their first trimester or one prenatal visit within 42 days of enrollment with Humana.
Tobacco cessation	For all enrollees 12 and older, up to eight health coaching/cessation support calls within 12 months from enrollment date. For enrollees 18 and older, nicotine replacement therapy on request. This program has two opportunities for enrollees to earn rewards: • $25 in rewards for enrollees who complete two calls within the first 45 days of enrollment in the coaching program, once per year. • $25 in rewards for enrollees who complete six additional Wellness Coaching calls (eight in total) within 12 months of the first coaching session, once per year.

Added benefits (cont'd.)

Healthy behavior rewards	Details and limitations
Weight management	Enrollment in weight management program, completion of a well-being check-up and form with their primary care provider (PCP), completion of six total wellness coaching calls within 12 months of enrollment date or return of the PCP form. This program has two opportunities for enrollees to earn rewards: • $10 in rewards: Enrollment in the weight management program - Completion of well-being checkup with primary care provider - Submission of PCP form • $30 in rewards: Completion of the program - Six wellness coaching calls within 12 months of the first coaching session
Well-child visits, 0-15 months	Up to $60 in rewards for enrollees birth to 15 months old who complete a well-child visit, $10 in rewards per visit with a six-visit limit. Enrollees who complete a seventh visit can earn an additional $40 in rewards.
Well-child visits, 16-30 months	Up to $20 in rewards for enrollees 16-30 months who complete a well-child visit, $10 in rewards per visit with a two-visit limit. Enrollees who complete a third visit can earn an additional $20 in rewards.
Wellness visit	$20 in rewards for enrollees 3 and older who complete one annual wellness visit.

Provider Services

Provider and enrollee rights and responsibilities

Humana Healthy Horizons in Kentucky-contracted healthcare providers have a responsibility to respect our enrollees' rights. Our enrollees are informed of their rights and responsibilities via the enrollee handbook.

Detailed information on provider and enrollee rights and responsibilities can be found in the provider manual located on the Humana website at Humana.com/HealthyKY.

Recredentialing

- Healthcare providers must be credentialed prior to network participation to treat Humana Healthy Horizons enrollees.
- Humana participates with the Council for Affordable Quality Healthcare (CAQH®) for applicable provider types.
  - To aid with credentialing and recredentialing activities, please continually maintain your CAQH application to ensure it is complete and current.
- Recredentialing occurs at least every 3 years. Some circumstances require shorter recredentialing cycles.
  - Humana Healthy Horizons leverages applications available via CAQH during the recredentialing cycle, as applicable by provider type.
  - If we are not able to access your CAQH application, CAQH does not support your provider type or the supporting documentation available via CAQH is expired or incomplete, providers receive a request to provide the necessary documentation prior to the 36-month anniversary date of the last credentialing cycle.
- Healthcare providers must be screened by and enrolled with Kentucky DMS to be considered for participation.
- In addition to being in good standing with Medicare, federal, state and local agencies, healthcare providers must not appear on the Terminated and Excluded Provider List published by Kentucky DMS.

Further details regarding Humana Healthy Horizons credentialing/recredentialing requirements can be found in the Humana Healthy Horizons in Kentucky Provider Manual at Humana.com/HealthyKY.

Provider status changes

Advance written notice of status changes, such as a change in address, phone or adding or removing a provider at your practice, should be sent to providerdevelopmentkywv@humana.com and kybhmedicaid@humana.com for behavioral health providers.

Timely status updates keep our records current and are critical to process your claims. Status updates also ensure our provider directories are up to date and reduce unnecessary calls to your practice. This information also is reportable to Medicaid and Medicare.

Type of change	Minimum notice required
New healthcare providers entering or providers leaving the practice, ownership changes or convictions	Immediate
Phone number change	10 calendar days
Address change	60 calendar days
Change in capacity to accept enrollees	60 calendar days
Healthcare provider's intent to terminate	90 days or as specified in provider agreement

Provider Relations

Humana Healthy Horizons' provider relations representatives provide support with the following:

- Assisting all network providers in navigating Humana resources
- Helping providers access resources for billing and coding issues
- Educating providers regarding new policy changes, system updates and availability standards
- Instructing on resolution processes and assisting with escalated issues
- Communicating important information with the provider network via meetings, newsletters, network notices and emails

Provider Relations

Your provider relations representative conducts required yearly onsite visits to PCP offices to offer education resources and ensure compliance for the following areas:

- Access and availability standards
- Privacy practices
- Health Insurance Portability and Accountability Act (HIPAA) policies and procedures
- Patient rights and responsibilities
- Provider resources
- Cultural competency
- Case management programs
- Encounter submissions
- Grievance and appeals process
- Kentucky Health Information Exchange (KHIE) participation
- Vaccines for Children Program
- Enrollee disenrollment processes

To find your assigned provider relations representative, please visit Documents and Resources for Kentucky Medicaid – Humana.

If you are unable to determine who your representative is, please email KYMCDPR@humana.com. For Medicaid claims related inquiries, please email KYMCDCRR@humana.com and include the name of your provider relations representative.

Clinical

Referrals

PCPs are enrollees' medical homes and coordinators of their care. Humana Healthy Horizons does not require referrals for enrollees to seek care from participating providers. Enrollees may self-refer to any participating provider*; however, Humana Healthy Horizons encourages enrollees to notify their PCP of other provider visits.

PCPs should regularly screen their patients for behavioral health disorders, including substance-use disorders, and make appropriate referrals.

If PCPs need assistance referring enrollees to appropriate behavioral healthcare, Humana Healthy Horizons' Case Management team can assist you and the enrollee. The Medicaid Case Management Form and instructions for submission can be found on the provider website at Humana.com/HealthyKY.

*Exceptions to this policy apply to enrollees eligible for participation in the Lock-in Program.

Referrals (cont’d.)

Healthcare providers are encouraged to implement Screening, Brief Intervention and Referral to Treatment (SBIRT) best practices for all enrollees who may be affected by a substance-use disorder.

Screening – Utilize a standard screening tool to assess risks for your patient.

Brief Intervention – Utilize clinical expertise to engage patients in a conversation about how risky behaviors are affecting them and develop the patient’s interest in treatment.

Referral to Treatment – Refer patient to treatment professionals who specialize in behavioral health or substance-use disorder treatment.

For referral and up-to-date openings in facilities for addiction treatment in Kentucky, please visit the KY Help Now website.

For more information on how to use SBIRT in your practice, please visit SAMHSA's SBIRT website.

Prior authorizations

- Humana Healthy Horizons requires prior authorization for certain services to facilitate care coordination as well as to confirm the services are provided according to Kentucky DMS coverage policies.
- Enrollee eligibility is verified when a prior authorization is issued; however, treating providers must confirm eligibility on the date of service. Humana Healthy Horizons is not able to pay claims for services provided to ineligible enrollees.
- Prior authorizations are required for specific services and medications. Please see the pharmacy section of this presentation for details on drug prior authorizations.
- Physicians and other healthcare providers should review the Kentucky Medicaid Prior Authorization List online at Humana.com/PAL.
- Prior authorization for services, including EPSDT special services, must be obtained prior to the date of service to determine medical necessity of the request.
- Information regarding public health emergencies and Kentucky's policies regarding authorization requirements can be found at Kentucky's COVID-19 status webpage.

Prior authorizations for medical procedures

Prior authorization for healthcare services can be obtained by contacting the Utilization Management department online or phone:

- Visit Availity Essentials at Availity.com.
- Call 800-444-9137 and follow the menu prompts for authorization requests, depending on your need, or fax the request to 833-974-0059.

Online authorizations

Online submission

- Fast and easy entry of authorizations through Availity
- Express entry feature
- Real-time responses
- Ability to add attachments
- Quick-print feature

Online management

- Access to last 18 months of authorization history
- Ability to update authorizations
- Status updates on submitted authorizations

Sign into Availity Essentials at

Availity.com

Prior authorization – What should be included in the request?

When requesting authorization, please provide the following information:

- Enrollee/patient name and Humana Healthy Horizons in Kentucky enrollee ID number
- Provider name, National Provider Identifier (NPI), Tax Identification Number (TIN) and contact information for ordering/servicing providers and facilities
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits or units of service requested, if applicable
- Reason for referring to an out-of-network provider, if applicable
- Clinical information to support the medical necessity of the service, including a current treatment plan and assessments when applicable
- Admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs, if the request is for inpatient admission for elective, urgent or emergency care
- Date of surgery, surgeon and facility name, admit date, admitting diagnosis and presenting symptoms, plan of treatment, all appropriate clinical review and anticipated discharge needs, if the request is for inpatient surgery
- Date of surgery, surgeon name, facility diagnosis and procedure planned and anticipated discharge needs, if the request is for outpatient surgery

Prior authorization partners

Humana Healthy Horizons in Kentucky partners with WholeHealth Networks (Tivity), eviCore healthcare, Avesis and New Century Health for prior authorization reviews.

eviCore healthcare

Provides authorization services for Kentucky Medicaid enrollees for the following services:

- 3D rendering
- Computed tomography angiography (CTA)
- Computerized tomography (CT) scan
- Magnetic resonance angiography (MRA)
- Magnetic resonance imaging (MRI)
- Nuclear medicine
- Positron emission tomography (PET)
- Single-photon emission computerized tomography (SPECT) scan
- Physical, occupational and speech therapy (PT/OT/ST)

Submit authorization requests to eviCore:

- Online at eviCore.com, opens new window (registration required)
- Call 866-672-8115, Monday – Friday, 7 a.m. – 7 p.m., Eastern time
- Fax advanced imaging services requests to 800-540-2406 or 855-774-1319 for PT/OT/ST services

Prior authorization partners (cont'd.)

Tivity

For all chiropractic services on the Kentucky DMS fee schedule, you must obtain prior authorization through Tivity. To submit a prior-authorization request to Tivity for chiropractic services:

- Use the Tivity online portal, wholehealthpro.com
- Call 855-800-9804, Monday – Friday, 8:30 a.m. – 5:30 p.m., Eastern time
- Fax 888-492-1025

Avesis

For authorizations related to dental and vision services, Humana Healthy Horizons in Kentucky partners with Avesis. To submit a prior authorization request to Avesis:

Dental

- Call 888-211-0599

Vision

- Call 844-511-5760

Prior authorization partners (cont'd.)

New Century Health

For adults 18 and older, Humana Healthy Horizons partners with New Century Health for chemotherapy agents, supportive and symptom management drug preauthorization requests. Choose from the following options to submit a request for preauthorization to New Century Health:

- Initiate an online preauthorization request by logging in to New Century Health's website at my.newcenturyhealth.com. Enter your username and password. If you have not yet received a username and password, please call New Century Health at 855-427-1372 and select option 1.
- Call New Century Health's intake coordinator department at 855-427-1372 and select option 1. Assistance is available Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

Please note: For a list of applicable drugs, please visit Humana.com/PAL. This list is subject to change with notification. However, this list may be modified throughout the year, without notification, via U.S. postal mail for additions of new to-market medications or step-therapy requirements for medications.

Prior authorization – Determination time frames

Standard determination

- Notice of decision is sent as expeditiously as the enrollee's health condition requires, but no later than two business days following receipt of the request for service.

Expedited determination

- When a provider indicates, or Humana Healthy Horizons determines, that following the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function, Humana will complete an expedited authorization decision within 24 hours and provide notice as expeditiously as the enrollee's health condition requires. Please specify in Availity Essentials or Humana Healthy Horizons in Kentucky Fax Form: Humana Preferred Template if you believe the request should be expedited.

Retrospective review

Humana Healthy Horizons only allows for a retrospective authorization submission after the date of service when a prior authorization is required but not obtained in the following circumstances:

- The service is related to another service that received prior approval, and the service was already performed.
- 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.
- The service is for Humana Healthy Horizons-covered patients who are determined to be retroactively eligible for Medicaid. (Retroactive Medicaid coverage is defined as a period of time up to three months prior to the application month.)
- Exception: A prior authorization obtained prior to an enrollee transitioning from another managed care organization to Humana Healthy Horizons will be upheld for the remainder of that prior-authorization approval time period.

Retrospective review (cont'd.)

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

- The date of service
- Inpatient discharge date
- Initial date of a service, for a service that spans several months
- Date of the primary insurance carrier's explanation of payment or authorization denial, which demonstrates the service was not a covered service

Requests for a retrospective review that do not meet one of the above requirements or exceed the 90-calendar-day time frame will be administratively denied.

Please include the following 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

Preventive health service and clinical practice guidelines

These clinical treatment protocols are systematically developed statements that help providers and enrollees make decisions regarding appropriate healthcare for specific clinical circumstances or for specific age ranges. We strongly encourage providers to use these guidelines and to consider these guidelines whenever they promote positive health outcomes for clients.

Humana Healthy Horizons uses the guidelines to measure the impact of quality care and monitors provider implementation of guidelines using claim, pharmacy and utilization data.

Preventive health guidelines and clinical practice guidelines are distributed to all new and existing providers via the following formats:

- Provider manual updates at Humana.com/HealthyKY
- Provider newsletters at Humana.com/NewHorizon
- Provider website at Humana.com/provider/medical-resources/clinical/guidelines

Access to care requirements

- Participating PCPs are required to ensure adequate accessibility for healthcare 24 hours a day, seven days a week and may not discriminate against enrollees.
- PCPs must maintain formalized relationships with other PCPs to refer enrollees for after-hours care, during certain days, for certain services and other reasons to extend the hours of services of their practice.
- Enrollees should be triaged and provided appointments for care within the time frames listed on the following slide.

Access to care requirements (cont'd.)

Primary care providers

Patients with:	Should be seen:
Emergency needs	Immediately on presentation; 24 hours a day, 7 days a week
Urgent care	Not to exceed 48 hours from date of an enrollee's request
Routine care needs	Not to exceed 30 days from date of an enrollee's request

Non-PCP specialists

Patients with:	Should be seen:
Emergency needs	Immediately on presentation
Urgent care	Not to exceed 48 hours
Routine care needs	Not to exceed 30 days from date of an enrollee's request

Access to care requirements (cont'd.)

Behavioral health providers

Patients needing:	Should be seen:
Emergency care	Must be provided within six hours, crisis stabilization
Care for non-life-threatening emergency	Within six hours
Urgent care	With 48 hours
Routine office visit	Shall not exceed 10 business days
Post discharge from an acute psychiatric hospital	Within seven days, and may not exceed 14 days*

*Providers must contact enrollees who have missed an appointment within 24 hours to reschedule.
General vision, dental, lab and X-ray wait times must not exceed 30 days for regular appointments and 48 hours for urgent care. Other visit types not specified above must not exceed 60 days.

PCP after-hours availability

Humana Healthy Horizons ensures the following acceptable after-hours phone arrangements are implemented by PCPs and unacceptable arrangements are amended:

- Acceptable after-hours phone arrangements:
  - Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner, and the PCP or designee is available to return the call within a maximum of 30 minutes.
  - Office phone is answered after hours by a recording directing the enrollee to call another number to reach the PCP or another medical practitioner whom the provider designated to return the call within a maximum of 30 minutes.
  - Office phone is transferred after office hours to another location where someone answers the phone and contacts the PCP or another designated medical practitioner within a maximum of 30 minutes.
- Unacceptable after-hours phone arrangements:
  - Office phone is only answered during office hours.
  - Office phone is answered after hours by a recording that tells enrollees to leave a message.
  - Office phone is answered after hours by a recording that directs enrollees to go to the emergency room for any services needed.
  - Return time for after-hours calls is outside of 30 minutes.

Enrollees with special healthcare needs

When a new/transitioning enrollee is actively receiving medically necessary covered services from the previous MCO:

- Humana Healthy Horizons provides continuation/coordination of medically necessary covered services for up to 90 calendar days or until the enrollee may be reasonably transferred without disruption, whichever is first.
- Humana Healthy Horizons may require prior authorization for continuation of the services beyond 30 calendar days; however, under these circumstances, authorization is not denied solely on the basis that the provider is not contracted with Humana.
- Continuity-of-care process information is available at Humana.com/HealthyKY.

Transitioning during pregnancy

- First trimester: Humana Healthy Horizons covers the costs of continued medically necessary prenatal care, delivery and postnatal care services without prior authorization and regardless of the provider's contract status until Humana Healthy Horizons can safely transfer the enrollee to a network provider without impeding service delivery.
- Second and third trimesters: Humana Healthy Horizons covers the costs of continued access to the prenatal care provider (whether the provider is contracted or not) for 60 calendar days postpartum, provided the enrollee remains covered through Humana Healthy Horizons, or referral to a safety-net provider if the enrollee's eligibility terminates before the end of the postpartum period.

Transitioning during pregnancy (cont'd.)

Medically necessary services covered by the previous MCO in addition to, or other than, prenatal services:

- Humana Healthy Horizons temporarily covers the costs of continuation of such medically necessary services.
- After 30 days, Humana Healthy Horizons may require prior authorization for continuation of services, but authorization is not denied at that point solely due to a provider's contract status.
- Humana Healthy Horizons may continue services uninterrupted for up to 90 calendar days or until the enrollee may be reasonably transferred without disruption, whichever is less.
- Continuity of care process information is available at Humana.com/HealthyKY.

Care Management overview

Care Management:

Humana Healthy Horizons manages and coordinates care for enrollees with special healthcare needs who require ongoing care management/chronic condition management. Outreach frequency is determined by individual enrollee needs, preferences and risk level.

Humana Healthy Horizons includes the following steps in its care management:

- Identifies enrollees through referrals from on-site/telephonic utilization management (UM) nurses, PCPs, specialists, enrollee self-referral, health needs assessment, predictive model algorithms, post-discharge assessments, etc.
- Obtains enrollees' permission/agreement to participate. (Enrollees may opt out at any time.)
- Completes a comprehensive assessment incorporating physical and behavioral health as well as social determinants of health (SDOH).
- Identifies key members of enrollees' interdisciplinary care team and engages the PCP.
- Creates an individualized comprehensive care plan with the enrollee and works toward identified goals.
- Makes available the individualized care plan to providers by contacting Humana Healthy Horizons or through Availity Essentials.

More information is available at Humana.com/HealthyKY.

Care Management functions

Humana Healthy Horizons also:

- Identifies triggers for emergency room (ER) visit/admission and partners with enrollees and their healthcare providers to prevent/reduce ER visits and unplanned inpatient admissions.
- Addresses Healthcare Effectiveness Data and Information Set (HEDIS®) measures for enrollees' gap reports or alerts on file.
- Refers to internal and external programs and community resources as needed (e.g., maternal health program, smoking cessation, food pantry resources, etc.).
- Coordinates and participates in interdisciplinary team meetings to identify the best course of action for improved outcomes based upon enrollee needs.
- Educates enrollees on disease process, self-care and value-added benefits.
- Supports and reinforces medical provider instructions and facilitates appointment scheduling and attendance.

Population Health Management (PHM)

PHM goal:

Use continuous quality improvement methodology to:

- Measure data
- Track trends
- Monitor outcomes
- Adjust the approach to achieve the Triple Aim

Overview

- Identifies enrollee needs and preferences.
- Employs strategies to improve health and well-being and implements interventions for priority populations.
- Identifies enrollees with emerging risks, significant behavioral health and SDOH issues, and segments of our population experiencing health disparities.
- Achieve the Triple Aim—better health, better care and better value by increasing providers' PHM capabilities by providing access to accurate and actionable data.
  - Availity Essentials provides a single location and consistent workflow to process transactions and securely access a wide range of financial, administrative and clinical transactions.
  - Compass is Humana's proprietary population health platform that offers providers robust data-sharing capabilities and provides additional insight into their patient panel. Providers can request core reports plus additional reports to help identify patients or groups requiring additional support.

For more information, please refer to the Provider Manual at Humana.com/HealthyKY.

PHM – Provider role and integrated healthcare

Humana Healthy Horizons employs a population health model that encompasses care management, data integration, population assessments, enrollee stratification and targeted interventions, based on priority populations. Our population health model also features quality measurement and enhanced PCP support models.

Population Insights Compass is a proprietary population health platform used to enhance Humana Healthy Horizons' PCP support within our population health model. To deliver additional insight into patient panels, we encourage PCPs to use Population Insights Compass' robust data-analysis capabilities to identify recommended health screenings for enrollees to improve health outcomes. More information is available at Humana.com/compass.

PCPs may request Compass reports from their provider engagement representatives to help identify patients or groups requiring additional support.

PHM – Integrated program that addresses social determinants of health and population health management initiatives

Population health is a foundational element of Humana Healthy Horizons' enterprise mission and a core component of our managed care programs. We assess our enrollees to:

- Identify needs and preferences
- Employ strategies to improve enrollees' health and well-being and implement interventions for priority populations
- Identify enrollees with significant behavioral health (BH) issues and deficient SDOH
- Support segments of our population experiencing health disparities

A PCP's utilization of electronic health records (EHRs) is a primary driver toward successful integration, as using EHRs facilitates real-time information exchange to promote continuity of care.

PHM – Integrated program that addresses social determinants of health and population health management initiatives (cont'd.)

To support our population health initiatives, providers are encouraged to refer enrollees with needs they have identified to our care management and PHM community resource programs by sending referrals to:

- Care Management: call 888-285-1121, fax a request to 833-939-1312 or email us at KYMCDCaseManagement@humana.com.
- Population Health: call <866-331-1577> or email us at KYMCDPopulationhlth@humana.com.

Providers should encourage enrollees to use Humana Healthy Horizons' population health tools:

- Go365®: Humana's wellness and rewards program, Go365 incorporates practices of behavioral economics and encourages enrollees to complete healthy activities, including preventive exams and the completion of the HRA. The custom Medicaid Go365 mobile app provides an experience designed specifically to meet the needs of our Kentucky Medicaid enrollees. On completion of key activities, participants can earn and redeem gift cards to popular retailers, such as Walmart, CVS and Amazon, which are delivered to the enrollee via email or mail.

PHM – Integrated program that addresses social determinants of health and population health management initiatives (cont'd.)

- KidsHealth®: A library of video modules and written content on pediatric BH and physical health conditions. KidsHealth content is designed to be accessible and readable by children, adolescents and adults, enabling younger enrollees to play a role in the self-management of their condition.
- Healthwise®: Provides disease-specific education and self-management support in an easy-to-read format. It is available across priority conditions and follows current clinical practice guidelines. Our care managers use the Healthwise database to deliver condition-specific content to our enrollees.
- Vida: Humana Healthy Horizons and Vida introduce an innovative digital therapeutic application proven successful at promoting better health through a prediabetes program and through blood sugar control among persons with diabetes. It reduces associated costs through real-time feedback on critical aspects of enrollee lifestyle and behavior. The diabetes app is designed to address clinically proven dimensions of diabetes management: exercise and sleep habits, diet, psycho-social factors such as stress, clinical symptoms, medication adherence and lab results such as blood glucose levels. Vida gives feedback to enrollees to promote self-management of critical behaviors such as diet and exercise and communicates lab results to enrollees and their clinical team.

PHM – Population Insights Compass access and training

Access

- Contact your provider engagement representative to request access to Population Insights Compass.
- To qualify for access, a PCP must have 30 or more Humana Healthy Horizons enrollees, be on the Path to Value continuum and have a signed business associate agreement on record with Humana Healthy Horizons.
- Once access is granted, PCPs receive an email from Microsoft Invitation to register an account.
- After registering your account, log in to Population Insights Compass at www.populationinsightscompass.humana.com.

Training

- Visit Humana.com/compass to register for interactive webinar training modules.
- Compass 101, a one-hour course that reviews navigating the tool and functionality, is a prerequisite before registering for other courses.

Chronic condition management

Programs

- Asthma; pediatric and adult
- Cancer
- Diabetes
- Congestive heart failure
- Hypertension
- HIV+/AIDS
- Mental health
- ADHD
- Depression and PTSD
- Substance-use disorder, including opioid-use disorder

Goal

Empower enrollees through education and development of self-management skills that foster treatment plan compliance and better health outcomes.

Overview

- Participation is voluntary and enrollees may opt out at any time.
- Referrals are received from claims data, on-site/telephonic nurses after discharge, PCPs, self-referral, internal/external programs, community partners, etc.
- Assessment includes health history, cognitive/psychological/depression screening, medication review, diet compliance.
- Creates an individualized education plan based on enrollee needs.
- Care manager coordinates care to meet identified needs and works with enrollee to set agreed-upon contact frequency and cadence.
- Educates enrollees about disease process, self-care and value-added benefits. Refers to internal and external programs and community resources as needed (e.g., maternal health program, smoking cessation, food pantry resources, etc.).
- More information is available at Humana.com/HealthyKY.

Enrollee incentive programs

Enrollee incentive programs

HumanaBeginnings – Prenatal, postpartum and well-baby visits

Healthy Behavior incentives – HbA1c check, digital rectal exam, Pap, mammogram, wellness visits

- Enrollee incentive programs are healthy behavior programs designed to help enrollees live a healthier lifestyle and maintain health.
- Enrollees can call Humana Healthy Horizons to find out how to enroll in incentive programs and find out more.

Maternal health and transition programs

HumanaBeginnings

- Manages prenatal and postpartum enrollees from onset of pregnancy up to eight weeks post-partum or eligibility loss
- Facilitates care coordination with Women, Infants and Children (WIC), Healthy Start and other internal/external programs

Transition support

- Supports enrollees as they transition out of inpatient care to the community
- Supports follow-up appointments
- Ensures delivery of at-home, post-discharge items
- Reviews discharge instructions and changes to medication

Interpretation/translation services

All providers are required to abide by federal and state regulations related to sections 504 and 508 of the Rehabilitation Act, Americans with Disabilities Act (ADA), Executive Order 13166 and Section 1557 of the Affordable Care Act (ACA), in the provision of effective communication, including:

- In-person or video-remote interpretation for deaf and hard-of-hearing patients and over-the-phone interpretation with a minimum 150 languages available for non-English speakers
- Services provided at no cost to the enrollee, per federal law

Cultural sensitivity

Humana Healthy Horizons offers a variety of resources to deliver healthcare services to all enrollees in ways that are respectful to the enrollee's ethnicity, socioeconomic status, culture and primary language, including:

- language assistance services
- detailed demographic information about contracted providers
- internal staff training
- Spanish resources

Other tools from health-related organizations are available that help acknowledge potential gaps in care and can help providers improve culturally competent care.

A copy of Humana Healthy Horizons' Cultural Competency Plan is provided at no charge and can be found online at Humana's language assistance and diversity webpage. To request a paper copy, please call Humana Healthy Horizons Provider Services at 800-444-9137.

Advance medical directives

PCPs have the responsibility to discuss advance medical directives at the first medical appointment with adult enrollees who are 18 or older and who are of sound mind. The discussion should:

- Be charted in the permanent medical record of the enrollee.
- Include a copy of the advance medical directive in the enrollee's medical record inclusive of other mental health directives.

Information on advance medical directives is included in the Humana Healthy Horizons for Kentucky Provider Manual located at Humana.com/HealthyKY.

Enrollee medical record reviews

Humana Healthy Horizons monitors a PCP's actions to ensure he/she complies with Kentucky DMS and plan policies including, but not limited to, the following:

- Maintaining continuity of the enrollee's healthcare
- Maintaining a current medical record for the enrollee, including documentation of all PCP and specialty care services
- Documenting all care rendered in a complete and accurate medical record that meets or exceeds the department's specifications

The completion of record reviews can result in the implementation of improvement plans and actions when standards are not met by the PCP. The enrollee medical records review process also assesses the effectiveness of practice site follow-up plans to increase compliance with established medical records standards and goals. The Humana Healthy Horizons in Kentucky Provider Manual, available at Humana.com/HealthyKY, includes details regarding medical record standards and reviews. Enrollee medical record reviews are implemented with methods for assessing performance and compliance with medical record standards that evaluate, at a minimum:

- PCPs' compliance with clinical and preventative care guidelines
- Tracking and trending of individual and network provider performance over time
- Mechanisms and processes that allow for the identification, investigation and resolution of quality-of-care concerns
- Mechanisms for detecting instances of over-, under- and misutilization

Enrollee medical record requirements

1. The plan ensures its network of providers maintains enrollee medical records on paper or in an electronic format and maintains timely, legible, current, detailed and organized information to permit effective and confidential patient care and quality review.
2. Complete medical records include, but are not limited to:
   - Medical charts
   - Prescription files
   - Hospital records
   - Provider specialist reports
   - Consultant and other healthcare professionals' findings
   - Appointment records
   - Other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of services provided under the contract
3. The medical record shall be signed by the healthcare provider of service.
4. The enrollee's medical record is the property of the healthcare provider who generates the record.
   - However, the plan requires that each enrollee or his/her representative is entitled to one free copy of his/her medical record.
     - Additional copies are made available to enrollees at cost.
   - Medical records generally are preserved and maintained by the provider for a minimum of five years, unless federal requirements mandate a longer retention period (e.g., immunization and tuberculosis records are required to be kept for a person's lifetime).
5. The plan ensures the PCP maintains a primary medical record for each enrollee containing sufficient medical information from all providers involved in the enrollee's care, to ensure continuity of care.

Enrollee medical record requirements (cont'd.)

6. The medical chart organization and documentation must contain, at a minimum, the following:
   a. Enrollee/patient identification information, on each page
   b. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and, if the Humana Healthy Horizons-covered patient does not have a phone number, numbers of emergency contacts, consent forms, language spoken and guardianship information
   c. Date of data entry and date of encounter
   d. Provider name
   e. Allergies and adverse reactions noted in a prominent location
   f. Past medical history, including serious accidents, operations and illnesses. For children, past medical history includes prenatal care and birth information, operations and childhood illnesses (e.g., documentation of chicken pox)
   g. Identification of current problems
   h. The consultation, laboratory and radiology reports containing the ordering provider's initials or other documentation indicating review
   i. Documentation of immunizations pursuant to 902 Kentucky Administrative Regulation (KAR) 2:060
   j. Identification and history of nicotine, alcohol use or substance use

Enrollee medical record requirements (cont'd.)

k. Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health, pursuant to 902 KAR 2:020
l. Follow-up visits provided secondary to reports of emergency room care
m. Hospital discharge summaries
n. Advance medical directives (for adults)
o. All written denials of service and the reason for the denial
p. Record legibility to at least a peer of the writer (Records judged illegible by one reviewer are evaluated by another reviewer.)

7. An enrollee's medical record should include the following minimal detail for individual clinical encounters:
   a. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health and substance-use disorder status
   b. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (e.g., EPSDT) addressed from previous visits
   c. Plan of treatment, including:
      i. Medication history and medications prescribed, including the strength, amount, directions for use and refills
      ii. Therapies and other prescribed regimens
      iii. Follow-up plans that include consultation, referrals and directions and an estimated time to return

Enrollee medical record requirements (cont'd.)

When documenting medical and mental health hospital visits, an enrollee's medical record must include, at minimum, the following:

1. Enrollee name/ID number
2. Physician name
3. Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission
4. The plan of care (as required under 42 C.F.R. 456.172 [mental hospitals] or 42 C.F.R. 456.70 [hospitals])
5. Initial and subsequent continued stay review dates (described under 42 C.F.R. 456.233 and 42 C.F.R. 465.234 [for mental hospitals] and 42 C.F.R. 456.128 and 42 C.F.R. 456.133 (for [hospitals])
6. Reasons and plan for continued stay, if applicable
7. For non-mental hospitals only, other appropriate supporting material to include:
    - Date of operating room reservation
    - Justification of emergency admission, if applicable

Reporting of communicable diseases

- Providers are expected to report instances of communicable disease in accordance with 902 KAR 2:020.
  - Contact the health department serving the county in which the enrollee resides.
  - Each county's health department has reporting requirements, such as reporting classifications and reporting methods, posted on their website.
  - Reporting is required of both positive and negative test results for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19.
  - Please visit the Cabinet for Health and Family Services' Infectious Disease website for a list of diseases and conditions that require reporting and instructions.

Claims Processing

Electronic claim submission

Claims clearinghouses*

- Availity Essentials www.availity.com
- Change Healthcare www.changehealthcare.com
- Waystar www.waystar.com
- TriZetto www.trizettoprovider.com
- SSI Group www.thessigroup.com

*Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for more information.

Resources

- Go to: Humana.com/ClaimResources
- Choose “Claims and encounter submission”

Humana payer IDs

61101 for fee-for-service claims

Avesis and vision and dental claim submission

Avesis Vision

Electronically:

- Change Healthcare (Formerly Emdeon)
  Payer ID 87098
  www.changehealthcare.com
  615-932-3000
- Trizetto
  Payer ID 86098
  www.trizetto.com
  800-569-1222

Mail a hard copy:

Avesis Third Party Administrators, Inc.
Attention: Eye Care Claims
P.O. Box 38300
Phoenix, AZ 85069-8300

Avesis Dental

Electronically:

- Through your practice management software using a clearinghouse (Avesis payer identification number 86098)
- Submitted via the Avesis provider portal

Mail a hard copy on an American Dental Association claim form:

Avesis Dental Claims
P.O. Box 38300
Phoenix, AZ 85069-8300

For more information regarding Avesis claims inquiries and payments please go to www.avesis.com or call Avesis Customer Service at 855-214-6777.

How to avoid claims submissions errors

Common reasons for claim submission rejection or denial:

- Providers submitting an incorrect NPI/taxonomy code
- Claims missing NPI/taxonomy code
- Providers submitting claims without a required billing/rendering/referring/ordering/attending NPI
- Providers submitting NPIs not enrolled/registered for Medicaid with Kentucky DMS
- Providers submitting claims with zero-dollar billed charges
- Providers submitting with a claim form (1500/UB04) that is not appropriate for their registered provider type
- Providers not submitting the correct claim payer ID
- Providers submitting claims with a referring/ordering/rendering/attending NPI registered as a group

How to avoid these errors:

- Confirm the provider information submitted exactly matches the provider information as it is registered with Kentucky DMS and in accordance with the services provided (e.g., NPI, Medicaid number, taxonomy code, provider specialty code, provider type code).
- Ensure that billing/rendering/referring/ordering/ attending NPIs on the claim are correct and are enrolled/registered with Kentucky DMS.
- If provider has an NPI registered to more than one active Medicaid number, a taxonomy code MUST be on the claim.
- Ensure billed amounts do not equal zero dollars (i.e., providers must submit billed charges).

Provider types required to bill with referring/ordering provider on claim

Billing provider type	Billing provider type descriptions
18	Private duty nursing
36	Ambulatory surgery center
37	Independent lab
50	Hearing aid dealer
52	Optician
54	Pharmacy: all crossover services billed
70	Audiologist
76	Multi-therapy agency
79	Speech language pathologist
86	X-ray/miscellaneous supplier
87	Physical therapy
88	Occupational therapist
90	Durable medical equipment (DME)

Providers submitting claims with a billing, rendering, referring, attending and/or ordering NPI must be registered with Kentucky DMS for Medicaid.

Timely filing

- Claims must be submitted within 365 calendar days of the date of service or discharge.
- Providers have 365 calendar days from the date of service or discharge to submit a corrected claim.
- The time frame for providers to submit an appeal is 60 calendar days from receipt of notice that payment for a submitted claim was reduced or denied.
- Claims, timely filing and HEDIS:
  - Providers are required to file their claims in a timely manner for all services rendered to enrollees. Timely filing is an essential component reflected in Humana Healthy Horizons' HEDIS reporting and can ultimately affect how a plan and its providers are measured in enrollee preventive care and screening compliance.
- Claims determined to have been incorrectly paid or denied by Humana Healthy Horizons do not require resubmission by the healthcare provider. Incorrectly processed claims are reprocessed and are not subject to timely filing requirements.
- Visit Humana.com/MakingItEasier for more information on claims and payment processes.

Payment options

Humana Healthy Horizons utilizes three payment options for providers:

- Paper check and remittance
- Virtual credit card payments (VCC)
- Electronic funds transfer (EFT)/Electronic remittance advice (ERA)

Paper check and remittance

- Default provider payment option
- Humana Healthy Horizons selects providers utilizing paper checks and remittance to participate in VCC

VCC

Humana partners with PNC Healthcare and ECHO Health Inc. to pay claims to eligible healthcare providers via virtual credit card (VCC). We notify healthcare professionals and organizations prior to their enrollment in virtual card payments. Healthcare providers may opt out of the program by calling ECHO at <888-483-9212>, Monday – Friday, 8 a.m. – 6 p.m., Eastern time, or enroll in EFT/ERA.

Claims payment: Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

Receive Humana Healthy Horizons payments via direct deposit into the bank account of your choice.

Get paid up to seven days faster than via mail.

Reduce the risk of lost or stolen checks.

Receive HIPAA-compliant ERA transactions.

Have remittances sent to your clearinghouse or view them online.

Reduce paper mail and time spent on manual processes.

Learn more, including how to enroll, at Humana.com/epaymentinfo.

Additional assistance with ERA/EFT setup

Contact us if your organization needs:

Payments deposited in **more than one bank account.**

Separate remittance information for different providers or facilities.

ERA/EFT setup for **multiple provider groups, facilities and/or individuals.**

You can reach Humana Healthy Horizons Provider Services at 800-444-9137.

Balance Billing

Per Humana Healthy Horizons in Kentucky Provider Manual:

- **Services that are not medically necessary:** The provider agrees that, in the event of a denial of payment for services rendered to enrollees determined by Humana not to be medically necessary, the provider shall not bill, charge, seek payment nor have any recourse against the enrollee for such services.

Humana Healthy Horizons in Kentucky Provider Manual and other provider communications can be found at Humana.com/HealthyKY.

Visit Humana.com/MakingItEasier for more information on claims and payment processes.

Electronic Health Records

Electronic Health Records (EHRs)

An EHR is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. While an EHR does contain the medical and treatment histories of patients, EHR systems are built to go beyond standard clinical data collected in a provider's office and can be inclusive of a broader view of a patient's care.

EHR assistance

Regional extension centers

- If providers need assistance selecting an EHR system, they can reach out to their local regional extension center (REC). RECs offer unbiased EHR implementation support throughout the implementation process. These organizations, funded by the Office of the National Coordinator for Health Information Technology, also serve as a two-way pipeline to local and federal resources. For more information, please visit kentuckyrec.com.
- RECs can help with EHR implementation and project management, vendor selection, workflow redesign, privacy and security, training, ongoing technical assistance and more. Please visit Healthit.gov/how-do-i/providers for more information.

Kentucky Health Information Exchange (KHIE)

- KHIE enables the secure exchange of enrollee health information between healthcare providers.
- Providers who contract with Humana Healthy Horizons sign a participation agreement with KHIE within one month of joining the Humana Healthy Horizons network. If providers need assistance connecting to other providers online, they can visit khie.ky.gov/Pages/index.aspx.

EHR incentive program

Humana Healthy Horizons encourages all healthcare professionals who meet the Electronic Health Record Incentive Program requirements to participate. Talk to your provider representative about the following:

- Collaboration with Kentucky RECs to promote EHR adoption and connectivity to KHIE
- EHR capabilities
- KHIE direct messaging
- Practice transformation incentives

For more information on how to attest and participate, please visit khie.ky.gov/Pages/index.aspx.

Provider Grievance and Appeals

Provider grievance and appeal

Providers have 60 days from the date on Humana Healthy Horizons' Notice of Adverse Determination or date of original claim submission denial to file a grievance or appeal. Grievances and appeals can be submitted to Humana Healthy Horizons using any of the following methods:

- Verbal submissions: please contact Humana Provider Services at 800-444-9137 or contact your provider relations representative.
- Written submissions:
  - Please mail to:
    Humana Provider Correspondence
    Grievance and Appeal Department
    P.O. Box 14546
    Lexington, KY 40512-4546
- Fax: 800-949-2961
- Online: Providers can submit encrypted grievances, view appeal documentation or check grievance and appeals status online via Availity Essentials.

Please note: Appeals are handled in accordance with Kentucky regulations.

What happens when Humana Healthy Horizons receives an appeal?

- Humana Healthy Horizons acknowledges the receipt of each appeal within five business days.
- For all standard appeals, Humana Healthy Horizons provides written notice of resolution within the 30-calendar-day time frame.
- If the appeal is not resolved within 30 calendar days, Humana Healthy Horizons requests a 14-day extension to resolve the matter.

Grievances submitted to Kentucky DMS

- Grievances submitted directly to Kentucky DMS using the state's forms are handled in our Critical Inquiries department.
- All critical inquiries are responded to as requested by Kentucky DMS within that specific inquiry.

What happens when Humana Healthy Horizons receives a grievance?

- Humana Healthy Horizons acknowledges the receipt of each grievance within five business days to the individual filing the grievance.
- The investigation and final resolution for standard grievances are completed within 30 calendar days.
- If the grievance is not resolved within 30 calendar days, Humana Healthy Horizons requests a 14-day extension to resolve the matter.

Expedited appeal

Expedited appeals may be requested on behalf of the enrollee and are resolved within 72 hours of the initiation of the expedited appeal process for enrollees.

- If the appeal is not resolved within 30 calendar days, Humana Healthy Horizons requests a 14-day extension to resolve the matter.

Claim dispute process

Humana Healthy Horizons established a formal claim dispute process to ensure timely resolution. Providers who have a contract or letter of agreement with Humana to provide Medicaid services in Kentucky can utilize this claim dispute process, pursuant to Kentucky Revised Statute (KRS) 304.17A-708. This process grants an opportunity for providers to dispute errors in payment in which the insurer has not paid the claim according to the contracted rate. The Claims Dispute Form and claim-dispute documentation must be received by Humana Healthy Horizons within 24 months of the original claim adjudication date.

Utilization Management

Health services and Utilization Management

Utilization Management: helps maintain the quality and appropriateness of healthcare services provided to Humana Healthy Horizons enrollees.

- Provides on-site and telephonic concurrent review and discharge planning
- Promotes effective level of care based on enrollee's individual needs
- Refers to appropriate Humana Healthy Horizons programs

Utilization Management

Front-end review clinician responsibilities:

- Reviews inpatient admissions for medical necessity during preauthorization or upon notification of admission.

Concurrent clinician responsibilities:

- Completes comprehensive discharge planning assessments on enrollees with inpatient admission.
- Conducts medical-necessity reviews on enrollees with continued inpatient stays.
- Collaborates with enrollee's healthcare team to maximize enrollee's benefits and resources and identifies enrollee's anticipated discharge planning needs.
- Conducts medical-necessity reviews for post-acute level-of-care requests in collaboration with medical director.
- Identifies and refers enrollees to internal Humana Healthy Horizons case management/disease management programs as appropriate.
- Refers enrollee to community resources or Humana Healthy Horizons social worker when social issues place enrollee at risk for readmission.

Discharge supports

Case Management:
When inpatient discharge notes indicate need for a Medicaid enrollee, Humana Healthy Horizons' Case Management collaborates with multiple areas to coordinate care.

- Referrals from on-site/telephonic UM nurses following discharge, PCPs, specialists, self-referral, internal/external programs, community partners, etc.
- Educates enrollees on disease process, self-care and value-added benefits, such as vision and dental coverage and unlimited medical transportation
- Completes post-discharge or post-ER visit telephonic outreach within three days of discharge (when applicable)
- Identifies gaps in care, addresses post-discharge needs and assists in making follow-up appointment(s) with PCP and specialists

Quality

Quality Assurance and Performance Improvement (QAPI) program

The QAPI program develops and monitors a cohesive plan of action to address enrollee needs across the continuum of care and influences outcomes related to the improvement of care and health of the entire enrollee population. Humana Healthy Horizons' Population Health Management (PHM) strategy is demonstrated through the QAPI program.

The QAPI program is an integrated program that supports PHM programs. Activities include, but are not limited to:

- Quality monitoring
- Community partnerships
- Collaboration with national organizations
- Cultural competency training and language support
- Access to web-based educational information
- Safety programs
- Data and information sharing, value-based relationships with providers
- Humana's Bold Goal initiative, including SDOH programs
- Provider engagement programs

Quality improvement requirements

Humana Healthy Horizons monitors and evaluates provider quality and appropriateness of care and service delivery (or lack thereof) to enrollees using the following methods:

- **Performance improvement projects (PIPs)** – Ongoing measurements and interventions which seek to demonstrate significant improvement in the quality of care and service delivery sustained over time, in both clinical care and nonclinical care areas, that have a favorable effect on health outcomes and enrollee satisfaction.
- **Medical record reviews** – Evaluate documentation patterns and adherence to enrollee record documentation standards of providers. Medical records also may be requested when investigating complaints of poor quality of service or clinical outcomes.
- **Performance measures** – Data collected on patient outcomes as defined by HEDIS or otherwise defined by the agency.
- **Surveys** – Consumer Assessment of Healthcare Providers and Systems (CAHPS), provider satisfaction, behavioral health surveys and special surveys to support quality/performance improvement initiatives.
- **Peer review** – Review of provider's practice methods and patterns to determine appropriateness of care.

External Quality Review Organization (EQRO)

Humana Healthy Horizons is required to participate in periodic medical record reviews. The Commonwealth of Kentucky retains an external quality review organization (EQRO) to conduct medical record reviews for Humana Healthy Horizons-covered enrollees. Providers may periodically receive requests from Humana Healthy Horizons for a review.

- Your contract with Humana Healthy Horizons requires that you furnish enrollee medical records to Humana for this purpose.
- EQRO reviews are a permitted disclosure of an enrollee's personal health information in accordance with HIPAA.
- Medical chart organization and documentation information is available in Humana Healthy Horizons in the Kentucky Provider Manual.

Quality improvement resource

Providers have access to a multitude of resources online, including:

- HEDIS resources
- CAHPS information
- Behavioral health guidelines
- Clinical practice guidelines
- Health and wellness resources

Providers are encouraged to use our population health programs to help enrollees achieve their best health. Please refer enrollees experiencing medical, behavioral health and/or substance-use disorder needs.

More quality resources are available at Humana.com/provider/medical-resources/clinical/quality-resources.

QAPI requirements

Healthcare providers may obtain a written QAPI program description by calling Provider Services at 800-444-9137. We welcome healthcare practitioners' input regarding our QAPI program.

Providers can request feedback by writing to the following address:

Humana Quality Management Department
321 W. Main St., WFP20
Louisville, KY 40202

More quality resources are available at Humana.com/provider/medical-resources/clinical/quality-resources.

Marketing Guidelines

Marketing guidelines

No marketing materials are distributed through Humana Healthy Horizons' provider network. If Humana Healthy Horizons supplies branded health education materials to its provider network, distribution is limited to Humana Healthy Horizons' enrollees, and materials are not to be made available to those visiting the provider's facility. Such branded health education materials do not provide enrollment or disenrollment information.

PCP Quality Recognition Programs

PCP Quality recognition programs

Humana Healthy Horizons is committed to decreasing costs and improving care in the communities we serve. Value-based programs allow PCPs the opportunity to earn financial incentives based on quality and clinical outcomes. The programs are designed based on the healthcare provider's panel size and engagement. The programs are reviewed and revised annually. Payment timelines will vary by program, allowing for reporting/data collection.

Humana Healthy Horizons

Primary Care Provider Quality Recognition Programs: Kentucky

Quality Plus

Annual incentives paid to provider practices for achieving quality measures

Program Highlights

- Practices are eligible for an incentive based on achieving targets for a subset of measures.
- Adult and pediatric membership categories are measured separately.
- HEDIS quality measures are updated annually within each category.

Requirements

- Contracted for the Medicaid line of business
- Meet a membership threshold of 30 paneled patients in adult and/or pediatric categories at the beginning and end of the measurement year

Model Practice

Quarterly incentives paid to provider practices for achieving individual quality, clinical and strategic measures[1]

Program Highlights

- Practices can earn a per-member-per-month **(PMPM)** incentive per target achieved.
- Opportunity for shared savings.
- **Adult** and **pediatric** membership categories are measured separately.
- HEDIS quality and clinical utilization measures are updated annually within each category.

Requirements

- Value-based contract with a Model Practice program attachment
- Meet a membership threshold of 250 paneled patients—100 paneled patients are required for adult and/or pediatric category eligibility

Provider Training Requirements

Additional training requirements

- Providers must complete additional annual required compliance training on the following topics:
  - General compliance and fraud, waste and abuse
  - Cultural competency
  - Health, safety and welfare (abuse, neglect and exploitation)
  - Others as required
- These trainings can be located on the following secure provider websites: Humana.com/ProviderCompliance and www.availity.com.
- **Be sure to complete the "Medicaid Partner Training Attestation" form to ensure completion is documented.**

Fraud, Waste and Abuse

Fraud, Waste and Abuse (FWA) reporting requirement and reporting options

Anyone who suspects or detects an FWA violation is required to report it either to Humana Healthy Horizons or within his/her respective organization, which then must report it to Humana Healthy Horizons via the following methods:

- **Telephone:**
  - Special Investigations Unit (SIU) Direct Line: 800-558-4444 ext. 1500724 (Monday through Friday, 8 a.m. to 4 p.m., Eastern time)
  - Special Investigations Unit Hotline: 800-614-4126 (24/7 access)
  - Ethics Help Line: 877-5-THE-KEY (877-584-3539)
- **Email:** siureferrals@humana.com or ethics@humana.com
- **Web:** www.ethicshelpline.com

All information will be kept confidential.

Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Also, Humana has a zero-tolerance policy for retaliation or retribution against any person who reports suspected misconduct.

FWA reporting information (cont'd.)

There are several ways you can alert the Kentucky Cabinet for Health and Family Services (CHFS) for investigation:

- By phone: 800-372-2970; Monday through Friday, 8 a.m. to 4:30 p.m., Eastern time
- In writing:

  Kentucky Cabinet for Health and Family Services

  Office of the Inspector General

  Division of Audits and Investigations

  275 E. Main St., 5 E-D

  Frankfort, KY 40621

False Claims Act

- The False Claims Act also permits a person with knowledge of fraud against the U.S. government to file a lawsuit (plaintiff) on behalf of the government against the person or business that committed the fraud (defendant).
- Individuals who file such suits are known as "whistleblowers." If the action is successful, the plaintiff is rewarded with a percentage of the recovery. Retaliation against individuals for investigating, filing or participating in a whistleblower action is prohibited.

Liability (31 U.S.C. 3729(a)(1) and (a)(3)): Liability for the foregoing acts includes:

- A civil penalty of $5,000 – $10,000
- Three times the amount of damages which the government sustains because of that act
- A person or company who violates the False Claims Act is also liable to the government for the costs of civil action brought to recover these penalties or damages

Disallowed Actions (31 U.S.C. §§ 3729-3733)

Links to the previously mentioned provisions of this act are listed within Humana's Compliance Policy for Contracted Health Care Providers and Business Partners, which is available at Humana.com/fraud.

Humana Websites and Numbers

Provider website – Public

Humana.com/HealthyKY

- Provider communications and network notices
- Provider documents and resources
- Provider training
- Health and wellness programs
- Clinical practice guidelines
- COVID updates and resources
- Prior authorizations
- Pharmacy services
- Claim resources
- Quality resources
- Provider Relations Representative assignment list

For questions about and assistance with the Humana.com sites, please call Provider Services at 800-444-9137.

Provider orientation and training revisions

This provider orientation and training document is reviewed and updated at least once a year. Orientation updates include, but are not limited to, the following:

- New or revised policy and procedures and administrative clinical practices
- Modifications to existing services
- New or amended Medicaid policies and procedures, including state and federal mandates

Updated versions of the Provider Orientation and Training document are posted on the Kentucky Medicaid provider website at Humana.com/HealthyKY.

Updates also are communicated via the provider newsletter at Humana.com/NewHorizon.

Working with Humana Healthy Horizons in Kentucky online? Use multipayer Availity Essentials

Availity Essentials is Humana Healthy Horizons' preferred method for online transactions.

- ✓ Use one consistent site to work with Humana and other payers.
- ✓ Check eligibility and benefits.
- ✓ Submit referrals and authorizations.
- ✓ Manage claim status.
- ✓ Use Humana-specific tools.
- ✓ Submit grievances.

About Availity Essentials

- Cofounded by Humana
- Humana Healthy Horizon's clearinghouse for electronic transactions with providers

How to register

- Go to Availity.com

Join us for a training session

- Visit Humana.com/ProviderWebinars to learn about training opportunities and reserve your space.

Questions

- Availity help with registration and tools: Call 800-AVAILITY (800-282-4548)
- Questions for Humana Healthy Horizons: Call Provider Services at 800-444-9137

Helpful contact information

- **Humana Healthy Horizons provider interactive voice response (IVR) line:** 800-444-9137
- **Prior-authorization (PA) assistance for medical procedures and medication billed as medical claim:** 888-285-1114
- **Medication intake team (prior authorization for medications administered in medical office):** 866-461-7273
- **Prior authorization for pharmacy drugs:** Call MedImpact at 844-336-2676
- **Medical and Behavioral Health Clinical Intake team:** 888-285-1114
- **Claim inquiries:** Send a detailed email to KYMCDCRR@humana.com

Helpful contact information (cont'd.)

- **24-hour nurse hotline:** <800-648-8097>
- **Behavioral health crisis line:** 833-801-7355
- **Medicaid care management:** 888-285-1121
- **Medicaid care and chronic condition management:** 888-285-1121
- **Availity Essentials customer service/tech support:** 800-282-4548
- **Ethics and compliance concerns:** 877-5 THE KEY (877-584-3539)
- **Reporting Medicaid fraud:** 800-614-4126
- **Information about arranging interpretation services for enrollee appointments:** 877-320-1235

Humana

Healthy Horizons®

in Kentucky