

Humana Health Plan Kentucky Medicaid Provider Manual

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Welcome

Welcome and thank you for becoming a participating provider with Humana Health Plan (Humana). We strive to work with our providers as partners to ensure that we make it as easy as possible to do business with us. This strong partnership helps facilitate a high quality of care and respectful experience for our enrollees.

We are a community-based health plan that serves Medicaid consumers throughout the Commonwealth of Kentucky.

Our goal is to provide integrated care for our enrollees. We focus on prevention and partnering with local providers to offer the services our enrollees need to be healthy.

As a managed care organization (MCO), Humana improves the health of our enrollees by utilizing a contracted network of high-quality providers. Primary care providers (PCPs) within the network provide a range of services to our enrollees and coordinate patient care by referring them to specialists when needed and ensuring timely access to healthcare services and appropriate preventive services.

Humana distributes the enrollee rights and responsibility statements to the following groups upon their enrollment and annually thereafter:

- New enrollees
- Existing enrollees
- New providers
- Existing providers

About Us

Humana is the nation's premier health benefits innovator with roots in Kentucky. We leverage our deep Medicaid experience and capitalize on proven expertise, strong resources and capabilities, established relationships and infrastructure.

Humana has the expertise, competencies and resources to make healthcare delivery simpler, while lowering costs and improving health outcomes. Our enrollees receive the highest quality of care and services by offering:

- Care management and care transitions programs
- Analytical tools to identify enrollees who might benefit from special programs and services
- An ongoing focus on customer service, health education and activities to promote health and wellness
- Community engagement and collaboration to ensure the comprehensive needs of enrollees are addressed
- Access to behavioral health services that includes crisis intervention and a dedicated hotline
- An award-winning history in enrollee services, training, clinical programs and customer satisfaction
- The ability to scale, innovate and provide ongoing support to our extensive provider network

Humana Makes a Difference

Humana brings a history of innovative programs and collaborations to ensure that our enrollees receive the highest quality of care. With a focus on preventive care and continued wellness, our approach is simple: We want to make it easier for our enrollees to get the healthcare they need, when they need it. Through community-based partnerships and services, we help our enrollees successfully navigate complex healthcare systems.

Humana has more than 50 years of managed care experience with the expertise and resources that come with it.

Our services include:

- Provider relations
- Enrollee eligibility/enrollment information
- Claim processing
- Decision-support informatics
- Quality improvement
- Regulatory
- Compliance
- Special investigations for fraud, waste and abuse
- Enrollee services, including an enrollee call center and a 24-hour nurse advice line

In addition to the above, our care management programs include the following:

- Case management
- Onsite case management (clinics and facilities)
- Emergency department diversion
 - High emergency department utilization focus (targeted at enrollees with frequent utilization)
 - 24-hour nurse advice line
- Maternal and healthy baby program
- Discharge planning and transitional care support
- Disease management program for asthma and diabetes

Compliance and Ethics

At Humana, we serve a variety of audiences: enrollees, providers, government regulators and community partners. We serve them best by working together with honesty, respect and integrity. We are all responsible for complying with all applicable state and federal regulations along with applicable Humana policies and procedures.

Humana is committed to conducting business in a legal and ethical environment. A compliance plan has been established by Humana that:

- Formalizes Humana's commitment to honest communication within the company and within the community, inclusive of our providers, enrollees and employees
- Develops and maintains a culture that promotes integrity and ethical behavior
- Facilitates compliance with all applicable local, state and federal laws and regulations
- Implements a system for early detection and noncompliance reporting with laws and regulations; fraud, waste and abuse concerns; or noncompliance with Humana policy, professional, ethical or legal standards
- Allows us to resolve problems promptly and minimize negative impact on our enrollees or business including financial losses, civil damages, penalties and sanctions

Following are general compliance and ethics expectations for providers:

- Act according to professional ethics and business standards
- Notify us of suspected violations, misconduct or fraud, waste and abuse concerns
- Cooperate fully with any investigation of alleged, suspected or detected violations of applicable state or federal laws and regulations
- Notify us if you have questions or need guidance for proper protocol

For questions about provider expectations, please call your Provider Relations Representative or call Provider Services at **1-800-444-9137**.

We appreciate your commitment to compliance with ethics standards and the reporting of identified or alleged violations of such matters.

Accreditation

Humana holds a strong commitment to quality. We demonstrate our commitment through programs based on national standards, when applicable. Humana holds accreditation from the National Committee for Quality Assurance (NCQA) for our Medicaid lines of business.

Communicating with Humana

Enrollee/Provider Services: 1-800-444-9137 (7 a.m. to 7 p.m., Monday through Friday)

24-Hour Nurse Advice Line (24/7/365): 1-800-648-8097

Other helpful phone numbers:

- Prior authorization (PA) assistance for medical procedures and behavioral health: 1-888-285-1114
- Prior authorization for pharmacy drugs: 1-800-555-2546
- Medicaid case management: 1-888-285-1121
- Availity customer service/tech support: 1-800-282-4548
- Fraud, Waste and Abuse
 - Special Investigations Unit (SIU) Hotline: 1-800-614-4126 (24/7 access)
 - Ethics Help Line: 1-877-5-THE-KEY (1-877-584-3539)

Mail

Correspondence

Humana
P.O. Box 14601
Lexington, KY 40512

Provider complaints

Humana
P.O. Box 14601
Lexington, KY 40512-4601

Enrollee grievance and appeals

Humana
P.O. Box 14546
Lexington, KY 40512-4546

Claims

Humana
P.O. Box 14601
Lexington, KY 40512

Fraud, waste and abuse

Humana
1100 Employers Blvd.
Green Bay, WI 54344

Helpful Websites

Humana.com

Providers may obtain plan information from [Humana.com/providers](https://www.humana.com/providers).

This information includes, but is not limited to, the following:

- Health and wellness programs
- Clinical practice guidelines
- Provider publications (including provider manual, newsletters, program updates)
- Pharmacy services
- Claim resources
- Quality resources
- What's new

For help or more information regarding web-based tools, please call **1-800-444-9137**.

Availity

Humana partnered with Availity to allow providers to reference enrollee and claim data for multiple payers using one login. Availity includes access the following benefits:

- Eligibility and benefits
- Referrals and authorizations
- Claim status
- Claim submission
- Remittance advice
- Enrollee summary
- Overpayment
- Electronic remittance advice/Electronic funds transfer

To learn more, call 1-800-282-4548 or visit www.Availity.com.

Enrollee Enrollment & Eligibility

Medicaid Eligibility

Medicaid eligibility is determined by the Department for Community Based Services (DCBS) in the county where the consumer resides.

The Commonwealth provides eligibility information to Humana on a daily basis via an 834 file for enrollees assigned to Humana. Eligibility begins on the first day of each calendar month for consumers joining Humana, with two exceptions:

1. Newborns, born to an eligible mother, are eligible at birth; and
2. Consumers who meet the definition of unemployed in accordance with 45 CFR 233.100 are eligible on the date they are deemed unemployed.

Newborn Enrollment

Humana begins coverage of newborns on the date of birth when the newborn's mother is an enrollee of a Humana Medicaid plan. The newborn will appear on the primary care physician's (PCP's) enrollee eligibility list after it is added to the Humana system.

You can verify eligibility for a newborn on the provider portal at www.availity.com. Refer to the [Verify Eligibility](#) section for instructions.

Disenrollment

Enrollees are disenrolled from Humana for a number of reasons. If an enrollee loses Medicaid eligibility, they lose eligibility for Humana benefits. Humana, the Department for Community Based Services (DCBS) or the enrollee can initiate disenrollment.

Enrollee disenrollment can be initiated for the following reasons:

- Unauthorized use of an enrollee ID card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the ability to provide services to the enrollee or others

Please notify enrollee services if one or all of the previously listed situations occur. Please see the section below for procedures for dismissing noncompliant enrollees from your practice. We can counsel the enrollee, or in severe cases, initiate a request to DCBS for disenrollment. DCBS reviews each enrollee disenrollment requests and determines if the request should be granted. Disenrollment from Humana always occurs at the end of the effective month.

Involuntary Dismissal

Participating providers can request that a Humana enrollee be involuntarily dismissed from their practice if an enrollee does not respond to recommended patterns of treatment or behavior.

Examples include:

- Noncompliance with medication schedules
- Violating no-show office policies
- Failing to modify behavior as requested

When an enrollee misses three or more consecutive appointments, providers are asked to notify our Care Management department for assistance. Humana requires that a provider's office make at least three attempts to educate the enrollee about noncompliant behavior and document them in the patient's record. Please remember that Humana outreach staff can assist you in educating the enrollee. After three attempts, providers may initiate dismissal procedures using the following guidelines:

- The provider's office must notify the enrollee of the dismissal by certified letter. The letter should include the reason for which the disenrollment is requested and the specific dates of the three documented unsuccessful education attempts.
- A copy of the letter must be sent or faxed to Humana at the following address:
Mail: Humana
Attn: Service Operations Resolution Team (SORT)
P.O. Box 221529
Louisville, KY 40252-1529

Fax: 1-937-226-6916

For PCPs only, the letter must contain the following specific language:

- The enrollee must contact Humana enrollee services to choose another PCP
- The reason for which the disenrollment is requested should include at least one of the following:
 - Incompatibility of the PCP-patient relationship
 - Patient has not utilized a service within one year of enrollment in the PCP's practice and includes the specific dates of 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 patient
- The dismissing PCP serves the affected patient until a new PCP can serve the patient, barring ethical or legal issues.

Referrals for Release Due to Ethical Reasons

Humana providers are not required to perform treatments or procedures that are contrary to the provider's conscience, religious beliefs or ethical principles, in accordance with 42 C.F.R 438.102.

The provider refers the enrollee to another provider who is licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition. The provider must be actively enrolled with the Commonwealth of Kentucky to provide Medicaid services to beneficiaries. The provider also must be in Humana's provider network.

In such circumstance, where the provider's conscience, religious beliefs or ethical principles require involuntary dismissal of the enrollee as his or her physician, the provider's office must notify the enrollee of the dismissal by certified letter.

The letter should include:

- Reason for the disenrollment request
- Referral to another provider licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition (The provider must be actively enrolled with the Commonwealth of Kentucky to provide Medicaid services to beneficiaries and must be in Humana's provider network)
- Instructions to contact Humana enrollee services at **1-800-444-9137** for assistance in finding a preferred in-network provider.
- A copy of the letter must be sent or faxed to Humana at the following address:
 - Mail: Humana
Attn: Service Operations Resolution Team (SORT)
P.O. Box 221529
Louisville, KY 40252-1529
 - Fax: 1-937-226-6916

Please call Provider Services at **1-800-444-9137** if you have questions about disenrollment reasons or procedures.

Automatic Renewal

If Humana enrollees lose Medicaid eligibility, but become eligible again within 60 days, they are automatically re-enrolled in Humana and assigned to the same PCP, if possible.

New Enrollee Kits

Each new enrollee household receives a new enrollee kit, a welcome letter and an ID card for each person in the family who has joined Humana. New enrollee kits are mailed separately from the ID card and new enrollee welcome letter.

The new enrollee kit contains:

- Information on how to obtain a copy of the Humana provider directory
- An enrollee handbook which explains how to access plan services and benefits
- A health assessment survey
- Other preventive health education materials and information

Enrollee ID Cards

All new Humana enrollees receive a Humana enrollee ID card. A new card is issued only when the information on the card changes, if an enrollee loses a card or if an enrollee requests an additional card.

The enrollee ID card is used to identify a Humana enrollee; it does not guarantee eligibility or benefits coverage. Enrollees may disenroll from Humana and retain their previous ID card. Likewise, enrollees may lose Medicaid eligibility at any time. Therefore, it is important to verify enrollee eligibility prior to every service.

Card Front:

Humana.	
Humana Health Plan	
ENROLLEE NAME	
Enrollee ID: HXXXXXXXXX	
Medicaid ID#: XXXXXXXX	Group #: XXXXXXXX
Date of Birth: XX/XX/XX	RxBIN: 610649
Effective Date: XX/XX/XX	RxPCN: 03191501
PCP Name: XXXXXXXXX	
PCP Phone: (XXX) XXX-XXXX	

Card Back:

Enrollee/Provider Service:	1-800-444-9137
Enrollee Behavioral Health Crisis Line:	1-833-801-7355
Pharmacist Rx Inquiries:	1-800-865-8715
24 Hour Nurse Line:	1-800-648-8097
Please visit us at Humana.com	
For online provider services, go to [www.availity.com]	
Please mail all claims to:	
Humana Medical	
P.O. Box 14601	
Lexington, KY 40512-4601	

- **Enrollee name**
- **Date of birth** – Enrollee’s date of birth
- **Humana enrollee ID number** – Use this number on claims.
- **Medicaid ID number** – Please do **not** use this number to bill Humana.
- **Primary care provider/Clinic name** – Each enrollee chooses a participating provider to be his or her primary care provider (PCP). If a choice is not made, a PCP is assigned.
- **Enrollee services** – Phone number and TTY for the hearing impaired.
- **24-hour nurse line** – Phone number to reach a registered nurse 24/7/365
- **Behavioral health hotline** – Enrollees can call this hotline 24/7/365 for mental health or addiction services.
- **Website** – Our website contains plan information and access to special functionality, like eligibility verification, claim and prior authorization submission, COB check and more.

- **Healthcare provider services** – Use this toll-free phone number if you have questions or wish to verify eligibility over the phone.
- **Mail medical claims to:**
Humana Claims Office
P.O. Box 14601
Lexington, Ky. 40512-4601
- **Pharmacy** – Call Provider Services if you have questions about pharmacy benefits and services.

Please note: Humana may be notified by the Commonwealth that an enrollee has lost eligibility retroactively. This occurs occasionally, and in those situations, Humana will take back payments made for dates when an enrollee lost eligibility. The take-back code will appear on the next Explanation of Payment (EOP) for impacted claims.

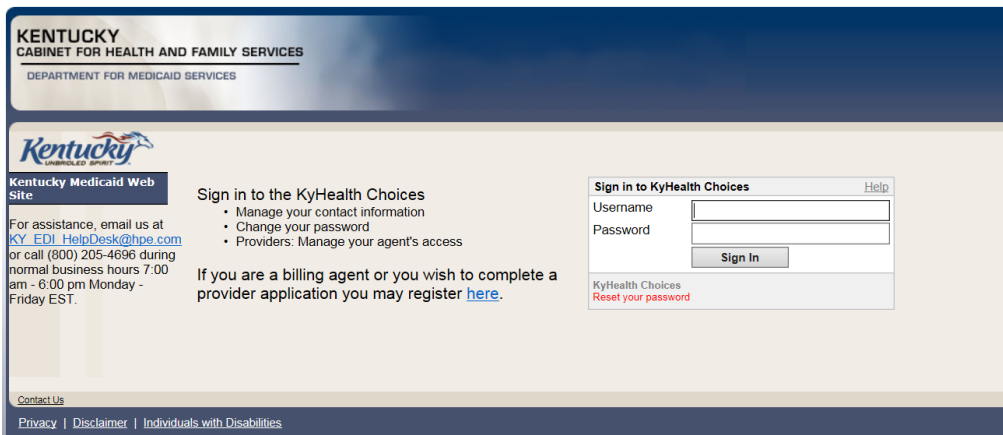
Verify Eligibility

Enrollees are asked to present an ID card each time services are rendered. If you are not familiar with the person seeking care and cannot verify the person as an enrollee of our health plan, please ask to see photo identification.

Before providing all services (except emergency services), providers are expected to verify enrollee eligibility via the HealthNet Portal at www.kymmis.com.

HealthNet

HealthNet is the Commonwealth’s web portal for access to enrollee eligibility, managed care organization enrollment and cost-share requirement validation information. It contains many of the tools necessary for enrollee administrative tasks. To access HealthNet, visit www.kymmis.com/kymmis/index.aspx. To find out more about HealthNet and to create a login, please visit www.chfs.ky.gov/agencies/dms/Pages/kyhealthnet.aspx.



HealthNet displays the enrollee’s date of eligibility, termination, cost-share requirement, the managed care organization with which they are enrolled and the Medicaid plan.

Providers also have access to verification resources on the Humana provider portal:

- Log on to the provider portal at **availity.com**. You can check Humana enrollee eligibility up to 24 months after the date of service. You can search by date of service plus enrollee name and date of birth, case number, Medicaid (MMIS) number or Humana enrollee ID number. You can submit multiple enrollee ID numbers in a single request.

Each month, primary care providers (PCPs) can view a list of eligible enrollees who have selected or are assigned to them as of the first day of that month. Log in to our provider portal at **availity.com** to view or print your enrollee list. Eligibility changes can occur throughout the month, and the enrollee list does not prove eligibility for benefits or guarantee coverage. Please use one of the previously described methods to verify enrollee eligibility for the date of service.

Enrollee Support Services and Benefits

Humana provides a wide variety of educational services, benefits and supports to our enrollees to facilitate their use and understanding of our services, to promote preventive healthcare and to encourage appropriate use of available services. We are always happy to work with you to meet the healthcare needs of our enrollees.

Enrollee Services

Humana can assist enrollees who have questions or concerns about services, such as case management, disease management as well as regarding benefits.

Representatives are available by telephone at **1-800-444-9137** Monday through Friday, 7 a.m. to 7 p.m. Eastern time, except on observed holidays. If the holiday falls on a Saturday, we will be closed on the Friday before. If the holiday falls on a Sunday, we will be closed the Monday after.

24-hour Nurse Advice Line

Enrollees can call 24 hours a day, seven days a week, 365 days a year. The toll-free number is listed on the enrollee's ID card. Enrollees have unlimited access with an experienced staff of registered nurses to talk about symptoms or health questions.

Nurses assess enrollees' symptoms, offering evidence-based triage protocols and decision support using the Schmitt-Thompson Clinical Content triage system, the gold standard in telephone triage.

Nurses educate enrollees about the benefits of preventive care and can make referrals to our Disease and Care Management programs. They promote the relationship with the primary care provider (PCP) by explaining the importance of the PCP role in coordinating the enrollee's care.

Key features of this service include:

- Assess enrollee symptoms
- Advise of the appropriate level of care
- Answer health-related questions and concerns
- Provide information about other services
- Encourage the PCP-enrollee relationship

Emergency Behavioral Health Services

For mental or behavioral health services, enrollees should call a contracted behavioral healthcare provider in their area. The behavioral healthcare provider can give the enrollee a list of common problems with behavior health symptoms and talk to the enrollee about how to recognize the problems. Enrollees may call Humana's Behavioral Health toll-free number at **1-800-444-9137**.

Behavioral Health Crisis Hotline

For emergency Behavioral Healthcare within or outside the service area, please instruct enrollees to go to the closest hospital emergency room or a recommended emergency setting. They should contact you first if they are not sure the problem is an emergency. Humana's emergency and crisis Behavioral Health Services Hotline, 1-833-801-7355, is staffed by trained personnel 24 hours a day, 7 days a week, 365 days a year, toll-free throughout the Commonwealth. Crisis hotline staff includes or has access to qualified behavioral health services professionals to assess, triage and address specific behavioral health emergencies.

Emergency mental or behavioral health conditions include:

- Danger to themselves or others
- Unable to carry out actions of daily life due to functional harm
- Serious harm to the body that may cause death

Disease Management

Humana enrollees with chronic conditions are eligible for enrollment in our disease management program. Enrollees who choose to participate in the program receive educational information on how to better manage their condition and care options for them to discuss with their provider. Enrollees identified as high risk are assigned a nurse who helps educate, coordinate and provide resources to the enrollee to optimize their overall health.

Chronic conditions include:

- Diabetes
- Asthma
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Enrollees with special healthcare needs
- Behavioral and substance abuse

If you have a Humana patient with any of these chronic conditions and you believe he or she would benefit from this program, please contact us by calling 1-888-285-1121 or email us at KYMCDCaseManagement@humana.com.

Care Management/Outreach

Humana provides comprehensive and integrated care management services through medical and behavioral health nurses, social workers and outreach specialists. We provide one-on-one personal interaction and support for enrollees. Additionally, we have pharmacists on staff to assist with medication reconciliation and we coordinate with community-based resources so that enrollees can address social determinants of health needs, such as accessing a food pantry, utility assistance, etc.

Our care management program provides a broad spectrum of educational and follow-up services for your patients. Care management is especially effective for reducing admission and re-admission risks, managing anticipatory transitions, engaging noncompliant enrollees, reinforcing medical instructions and assessing social needs. Humana also has a care management program designed for educating pregnant women and first-time mothers on the importance of prenatal care, childbirth, postpartum and infant care. We offer individualized education and support for many diseases.

Referrals

We encourage you to refer enrollees who might need individual attention to help them manage special healthcare challenges. Direct access for care management referrals and assistance with enrollee needs is available by calling 1-888-285-1121, by faxing request to 1-833-939-1312 or emailing us at KYMCDCaseManagement@humana.com.

Services

Humana's Care Management program is a fully integrated health management program, supporting a holistic approach by integrating physical and behavioral health while also considering environmental factors that impact health, such as food insecurity. We implement a personalized approach, supporting enrollees from their initial assessment through the continuum of care with the goal of enrollees taking an active part in their healthcare and making healthy lifestyle decisions. We take an enrollee-centric approach placing the enrollee at the center of the process and work to identify their goals and health priorities and support them in meeting those goals. This approach also supports and enhances the care and treatment you provide to your patient. We stress the importance of establishing the medical home, early and ongoing identification of barriers to care and keeping appointments. If necessary, we assist in arranging transportation to the provider's office.

Humana encourages you to take an active role in your patient's care management program and we invite and encourage you to direct and participate in the development of a comprehensive care plan as part of your patients' multi-disciplinary care team. We believe communication and coordination are integral to ensure the best care for our enrollees.

High-risk Enrollees

Humana provides a comprehensive integrated care management model for our highest-risk enrollees. Utilizing nurses and social workers, this multi-disciplinary approach integrates standards of practice to help enrollees overcome healthcare access barriers. We also strengthen our provider and community resource partnerships by managing enrollees through a collaborative effort within a multi-disciplinary care team.

High-risk enrollees often have multiple medical issues, socioeconomic challenges and behavioral healthcare needs. The multi-disciplinary care management teams are led by experienced care managers that perform a comprehensive assessment incorporating physical and behavioral health, along with socioeconomic needs, to develop an individualized treatment plan. The care management team then sets an ongoing contact schedule to monitor outcomes and evaluate progress for possible updates to the care plan based upon enrollee needs and preferences. Your patient's care plan is viewable by accessing the provider portal or request a copy by calling us at 1-888-285-1121.

Prenatal Care Management

Humana has a program for perinatal and neonatal care management utilizing a staff of specialized nurses. Nurses are available to help manage high-risk pregnancies and premature births by working in conjunction with providers and enrollees.

The expertise offered by the staff includes a focus on patient education and support and involves direct telephone contact with enrollees and providers. We encourage our prenatal care providers to notify Care Management Support Services at 1-888-285-1121 when an enrollee with a high-risk pregnancy is identified.

Prenatal Risk Assessment Forms (PRAFs)

Humana is committed to help providers manage high-risk pregnancies of our enrollees. We ask prenatal care providers use prenatal risk-assessment forms to communicate critical information to us about our pregnant enrollees. This information is made available to our care management team for outreach to enrollees as necessary.

Please remember the following guidelines when submitting prenatal risk assessment forms:

- Use a form designed for prenatal risk assessment documentation, such as the American College of Obstetrics and Gynecology (ACOG) form, the Hollister form or the Pregnancy Risk Assessment Form

provided by Humana. You may use your own office assessment form if you have one that captures the same information.

- Send completed forms, filled out as completely as possible, no later than four weeks after the enrollee's first prenatal visit.
- Please be sure to include the enrollee's estimated delivery date (EDD) on the form.
- You may use the Notice of Pregnancy Form on our Provider Portal at **availity.com**.
- We accept copies or originals by fax or mail. Please fax forms to 1-833-939-1317 or e-mail them to **KYMCDMomsFirst@humana.com**.

We accept up to three assessment forms per pregnancy if additional forms are needed for changes noted during subsequent visits.

Healthy Behaviors Program and Incentives

Healthy Behaviors are programs offered by Humana that encourage and reward behaviors designed to improve the enrollee's overall health. Enrollees can earn gift cards by completing specific services in the programs listed below. Programs administered by Humana must comply with all applicable laws, including fraud and abuse laws that fall within the purview of the U.S. Department of Health and Human Services Office of Inspector General (OIG). The following Healthy Behaviors programs are offered to Humana enrollees:

Prenatal and Postpartum and Baby Well Visits – Enrollees can earn rewards for completing the following activities:

- First prenatal visit
- Fifth prenatal visit
- Twelfth prenatal visit
- Postpartum appointment (between three to eight weeks postpartum)
- Seven well-child visits (to 18 months) – individual gift card per appointment received

Preventative Service Rewards – Enrollees can earn rewards for completing the following activities:

- Diabetes A1c screening
- Diabetes retinal eye screening
- Diabetes micro-albumin
- Pap smear
- Mammogram
- Annual dental cleaning

Smoking Cessation – Enrollees can be self-, plan- or provider-referred by calling 1-888-285-1121.

- Third call with coach
- Fifth call with coach

There are prenatal smoking cessation initiatives that include:

- Initial enrollment

- Fourth call with coach
- Twelfth call with coach

Once the enrollee is identified and placed in the program, Humana may inform them about healthy behavior programs, including incentives and rewards. Incentives and rewards cannot be used for gambling, alcohol, tobacco or drugs (except for over-the-counter drugs). All programs, including incentives and rewards, are made available to all enrollees who meet the requirements of each program. Incentives and rewards are not used to direct enrollees to select a certain provider. The maximum reward dollar amount on incentives and rewards does not include money spent on transportation, child care provided during delivery of services or healthy behavior program services.

Incentives and rewards may take 90 to 180 days or longer to receive. Incentives and rewards are not transferable to other managed care plans or other programs. Enrollees will lose access to earned incentives and rewards if they voluntarily disenroll from the Humana Health Plan or lose Medicaid eligibility for more than 180 days.

Interpreter Services

Hospital and nonhospital providers are required to abide by federal and state regulations related to the 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; this includes in-person or video-remote interpretation for deaf patients and over-the-phone interpretation with a minimum 150 languages available for non-English speakers.

These services are available at no cost to the patient or enrollee per federal law.

Health Education

Humana enrollees receive health information from Humana through a variety of communication methods, including easy-to-read newsletters, brochures, phone calls and personal interaction. Humana also sends preventive care reminder messages to enrollees via mail and automated outreach messaging.

Covered Services

General Services

Humana, through its contracted providers, is required to arrange for the following medically necessary services for each patient:

- Alternative birthing center services
- Ambulatory surgical center services
- Behavioral health services – mental health and substance abuse disorders
- Chiropractic services
- Community mental health center services
- Dental services, including oral surgery, orthodontics and prosthodontics
- Durable medical equipment, including prosthetic, orthotic devices and disposable medical supplies
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening and special services
- End-stage renal dialysis services
- Family planning services in accordance with federal and state law and judicial opinion
- Hearing services, including hearing aids for enrollees younger than 21
- Home health services
- Hospice services (non-institutional only)
- Independent laboratory services
- Inpatient hospital services
- Inpatient mental health services
- Meals and lodging for appropriate escort of enrollees
- Medical detoxification, i.e., management of symptoms during the acute withdrawal phase from a substance to which the enrollee is addicted
- Medical services, including but not limited to, those provided by physicians, advanced practice registered nurses, physicians assistants and federally qualified health centers (FQHCs), primary care centers and rural health clinics (RHCs)
- Organ transplant services not considered investigational by Federal Drug Administration (FDA)
- Other laboratory and X-ray services
- Outpatient hospital services
- Outpatient mental health services
- Pharmacy and limited over-the-counter drugs, including mental/behavioral health drugs
- Podiatry services
- Preventive health services, including those currently provided in public health departments, FQHCs/primary care centers, and RHCs
- Psychiatric residential treatment facilities (Level I and Level II)
- Specialized case management services for enrollees with complex chronic illnesses (includes adult and child targeted case management)
- Specialized children's services clinics
- Targeted case management
- Therapeutic evaluation and treatment, including physical therapy, speech therapy and occupational therapy
- Transportation to covered services, including emergency and ambulance stretcher services
- Urgent and emergency care services
- Post-stabilization care services, in accordance with 42 C.F.R. 422.113(c) and 438.114(e)

- Vision care, including vision examinations, services of opticians, optometrists and ophthalmologists, including eyeglasses for enrollees younger than 21

Behavioral Health and Substance-use Services

Behavioral health and substance-use services are covered services for Humana enrollees. Humana recognizes that behavioral health and physical health function as a part of the whole person, and one can affect the other. Therefore, we use a holistic approach to addressing behavioral health and substance use. Humana provides a comprehensive range of behavioral health services, including:

- Outpatient coverage for medication management, therapy services (individual, group and family therapy) and case management offered through key providers
- A broad range of hospital-based services for both behavioral health and substance dependence disorders such as intensive outpatient, partial hospitalization, crisis stabilization, long- and short-term inpatient stays based on medical necessity.
- Access to community-based resources

Providers, enrollees or other responsible parties can contact Humana at **1-800-444-9137** to verify available behavioral health and substance-use benefits and to seek a referral or direction for obtaining behavioral health and substance-use services.

Humana's network focuses on improving the health of our enrollees through efforts aimed at increased well-being, using enrollee centered evidence-based practices. Our goal is to provide the level of care needed by the enrollee in the least restrictive setting – the right care, at the right time and in the right setting.

Screening and Evaluation

Humana requires that primary care providers (PCPs) have screening and evaluation procedures in place for the detection and treatment of, or referral for, known or suspected behavioral health problems and disorders. PCPs may provide clinically appropriate behavioral health services within the scope of their practice.

Humana provides training to network PCPs on how to screen and identify behavioral health disorders, on Humana's behavioral health services referral process and on clinical coordination requirements for such services. Humana also includes coordination and quality of care training and new models of behavioral health interventions.

Care Management and Care Coordination

Humana enrollees have access to care managers who provide a holistic approach to addressing the enrollee's physical and behavioral healthcare needs as well as social determinant issues. Humana also offers chronic condition management programs for behavioral health and substance use. Humana's providers may contact Humana to refer enrollees needing care management assistance by calling **1-888-285-1121** or via email KYMCDCaseManagement@humana.com. Humana adheres to a "no-wrong door approach" to care management referrals.

Behavioral health service providers are required to refer enrollees with known or suspected and/or untreated physical health problems or disorders to their PCP for examination and treatment, with the enrollee's or the enrollee's legal guardian's consent. Behavioral health providers may only provide physical health care services if they are licensed to do so.

Humana assists with provider referrals, scheduling appointments and coordinating an integrated approach to the enrollee's health and well-being by coordinating care between behavioral health providers, PCPs and specialists. Behavioral health providers are required to send initial and quarterly summary reports to the enrollee's PCP and to refer enrollees for PCP follow up on untreated physical health concerns when identified.

For further information about our integrated care management programs, please refer to the section in this handbook on Enrollee Support Services and Benefits.

Continuation of Treatment

For enrollees receiving inpatient behavioral health services, Humana requires providers to schedule an outpatient follow-up appointment prior to the enrollee's discharge from the facility. The outpatient follow-up must be scheduled to occur within seven days from the date of discharge. Behavioral health providers are expected to contact patients within 24 hours of a missed appointment to reschedule.

Early and Periodic Screening and Diagnosis and Treatment (EPSDT)

EPSDT is a federally mandated program developed for Medicaid recipients from birth through the end of their 21st birth month. All Humana members within this age range should receive age-recommended EPSDT preventive exams, health screens and EPSDT special services needed to address health issues as soon as identified or suspected.

EPSDT benefits are available at no cost to enrollees.

EPSDT Preventive Services

The EPSDT program is designed to provide comprehensive preventive healthcare services at regular age intervals. Regular EPSDT preventive visits find health issues early (including physical health, mental health, growth and developmental) so additional testing, evaluation or treatment can start right away. EPSDT preventive services are available at the recommended ages and at other times when needed.

EPSDT stresses health education to children and their caretakers related to early intervention, health and safety risk assessments at every age, referrals for further diagnosis and treatment of problems discovered during exams and ongoing health maintenance.

Covered services EPSDT preventive exam components include:

- Comprehensive health and development history
- Comprehensive unclothed physical examination
- Laboratory tests, including (where indicated) blood-lead level screening/testing, anemia test using hematocrit or hemoglobin determinations, sickle-cell test, complete urinalysis, testing for sexually transmitted diseases, tuberculin test and pelvic examination
- Developmental screening/surveillance, including autism screening
- Sensory screenings and referrals for vision and hearing
- Nutritional assessment, including body mass index (BMI) and blood pressure
- Dental screenings and referrals to a dentist, as indicated (dental referrals are recommended to begin during a child's first year of life and are required at two years and older)
- Psychological/behavioral assessments, substance-use assessments and depression screenings
- Assessment of immunization status and administration of required vaccines

- Health education and anticipatory guidance (e.g., age-appropriate development, healthy lifestyles, accident and disease prevention, at-risk and risk behaviors and safety)
- Referral for further evaluation, diagnosis and treatment

EPSDT Special Services

Under the EPSDT benefit, Medicaid provides comprehensive coverage for any service described in section 1905(a) of the Social Security Act. 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:

- Special services included in EPSDT benefit may be 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 that are subject to medical necessity often require prior authorization.
- Consideration by the payer source must be given to the child's long-term needs, not only immediate needs and consider all aspects such as physical, developmental, behavioral, etc.

EPSDT Exam Frequency

The Humana EPSDT Periodicity Schedule is updated frequently to reflect current recommendations of the AAP and Bright Futures. To view updates to the schedule, please visit www.kyaap.org.

Infancy

Less than 1 month	2 months	4 months
6 months	9 months	12 months

Early childhood

15 months	18 months	24 months
30 months	3 years	4 years

Middle childhood

5 years	6 years	7 years
8 years	9 years	10 years

Adolescence and young adults

11 years	12 years	13 years
14 years	15 years	16 years

17 years	18 years	19 years
20 years	21 years (through the end of the enrollee's 21st birth month)	

Child Blood-lead Screenings

The Kentucky Medicaid Department for Public Health Childhood Lead Poisoning Prevention Program (CLPPP) requires that children receive a blood-lead level test at one and two years. Federal regulation requires that all children receive a blood test for lead at:

- 12 months and 24 months
- 36 months and 72 months for children who have not had a previous blood lead screening

This is a required part of the EPSDT exam provided at these ages.

Lead screening test specifications

- Kentucky Medicaid requires healthcare providers to provide blood-lead screening at 12 months and 24 months.
- Children 6 months to 6 years per the AAP: CMS requires each state to use a periodicity schedule to provide EPSDT services at age-recommended intervals that meet reasonable standards of medical practice. Kentucky uses the periodicity schedule published by the AAP and Bright Futures; 907 KAR 11:034.
- All children 72 months of age and younger and pregnant women who, per KRS 211.900:
 - Reside in dwellings or dwelling units which were constructed and painted prior to 1978
 - Reside in geographic areas defined by the cabinet as high risk
 - Possess one or more risk factors identified in a lead poisoning verbal risk assessment approved by the cabinet

Taking Centers for Disease Control and Prevention (CDC) guidelines and recommendations into account as well as Kentucky laws, children or pregnant women with confirmed elevated blood-lead level greater than 5µg/dL will be provided case management services by the local health department. Children and pregnant women with a confirmed blood-lead level greater than 15µg/dL requires public health environmental action per KRS 211.905 and a comprehensive environmental lead home inspection/risk assessment.

Immunizations

Immunizations are an important part of preventive care for children and should be administered during well-child/EPSDT exams as needed. Humana endorses the same recommended childhood immunization schedule recommended by the Centers for Disease Control and Prevention and approved by the Advisory Committee on Immunization Practices (ACIP), the AAP and the American Academy of Family Physicians (AAFP). This schedule is updated annually and current updates can be found on the AAP website at www.aap.org.

Services Not Covered

Humana must provide covered services under current administrative regulations. The scope of services may be expanded with approval of the Kentucky Department for Medicaid Services (KDMS) and as necessary to comply with federal mandates and state laws. Certain Medicaid services are currently excluded from the Humana's

benefits package, but continue to be covered through the traditional fee-for-service Medicaid Program. Humana is familiar with these excluded services, designated Medicaid “wrap-around” services and coordinates with KDMS’ providers in the delivery of these services to enrollees.

Information relating to these excluded services’ programs may be accessed by Humana from KDMS to aid in the coordination of the services.

Under federal law, Medicaid does not receive federal matching funds for certain services. Some of these excluded services are optional services that KDMS may or may not elect to cover. Humana is not required to cover services that KDMS has elected not to cover for enrollees.

The following services currently are not covered by the Kentucky Medicaid program:

- All laboratory services performed by a provider without current certification in accordance with the Clinical Laboratory Improvement Amendment (CLIA) (This requirement applies to all facilities and individual providers of any laboratory service)
- Cosmetic procedures or services performed solely to improve appearance
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only
- Medical or surgical treatment of infertility (e.g., the reversal of sterilization, in-vitro fertilization, etc.)
- Induced abortion and miscarriage performed out-of-compliance with federal and Kentucky laws and judicial opinions
- Paternity testing
- Personal service or comfort items
- Post-mortem services
- Services, including but not limited to drugs that are investigational, mainly for research purposes or experimental in nature
- Sex transformation services
- Sterilization of a mentally incompetent or institutionalized enrollee
- Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid program regulations referenced herein
- Services for which the enrollee has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage

Out-of-network Care for Services Not Available

Humana arranges for out-of-network care if it is unable to provide enrollees with necessary covered services, a second opinion or if a network healthcare provider is not available. Humana coordinates payment with the out-of-network provider to confirm that cost to the enrollee is not greater than it would be if the service were provided in-network.

Value-added Services

Value-added services (VAS) are those services offered by Humana and approved in writing by KDMS that are not otherwise covered or that exceed limits outlined in the in the Kentucky State Plan and the Kentucky Medicaid Fee Schedules. These services are in excess of the amount, duration and scope of those services listed above.

In instances where a VAS is also a Medicaid covered service, Humana administers the benefit in accordance with all applicable service standards pursuant to our contract, the Kentucky Medicaid State Plan and all Medicaid Coverage and Limitations Handbooks.

Humana Medicaid enrollees have specific enhanced benefits. Please see the enrollee handbook for benefit descriptions and details. Humana VAS programs include:

- Child obesity program
- Dental Services – additional cleaning for enrollees 21 and older
- Mom’s First Gift Card program – up to \$150 in gift cards for various incentives
- Healthy Behaviors Gift Card program – up to \$70 in incentives for receiving certain services
- Text Program for Expectant Mothers
- General Education Development (GED) testing
- Criminal expungement services
- Cell phone services
- Immunizations – Allowance of an additional vaccine for enrollees older than 21 (e.g., rabies)

Direct Access

Humana makes covered services available and accessible to enrollees as specified by the KDMS and in accordance with 42 C.F.R. 438 and applicable state statutes and regulations. Humana routinely evaluates out-of-network utilization and contacts high-volume providers to determine if they are qualified and interested in enrolling in Humana’s network. If so, Humana enrolls the provider as soon as the necessary procedures are completed.

When an enrollee wishes to receive a direct-access service or receives a direct-access service from an out-of-network provider, Humana contacts the provider to determine if it is qualified and interested in enrolling in the network. If so, Humana enrolls the provider as soon as the necessary enrollment procedures have been completed.

Humana ensures direct access and may not restrict the choice of a qualified provider by an enrollee for the following services within the network:

- Primary care vision services, including the fitting of eye glasses, provided by ophthalmologists, optometrists and opticians
- Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists
- Voluntary family planning in accordance with federal and state laws and judicial opinion
- Maternity care for enrollees younger than 18
- Immunizations to enrollees younger than 21
- Sexually transmitted disease screening, evaluation and treatment
- Tuberculosis screening, evaluation and treatment
- Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions and other communicable diseases as defined by 902 KAR 2:020
- Chiropractic services
- For enrollees with special health care needs determined through an assessment that need a course of treatment or regular care monitoring, allow enrollees to directly access a specialist as appropriate for the enrollee’s condition and identified needs
- Women’s health specialists

Pharmacy

Humana pharmacy provides coverage of medically necessary medications, prescribed by Medicaid certified licensed prescribers in the state.

Formulary

Humana utilizes a preferred drug list (PDL), a list of the preferred drugs covered for the enrollees' benefit. Our Pharmacy and Therapeutics Committee (P&T), which consists of practicing physicians and pharmacists across clinical specialties, identifies all covered legend and over-the-counter drugs, as well as certain supplies and select vitamin and mineral products available under the pharmacy benefit. The PDL identifies covered drugs and associated drug utilization management requirements, such as prior authorization, quantity limits, step therapy, etc.

Prior Authorization

For medications requiring prior authorization or a formulary exception, Medicaid providers may:

- Obtain forms at [Humana.com/PA](https://www.humana.com/PA)
- Submit requests electronically by visiting www.covermy meds.com/epa/humana
- Submit requests by fax to 1-877-486-2621
- Call Humana Clinical Pharmacy Review (HCPR) at 1-800-555-CLIN (1-800-555-2546).

Step Therapy, Therapeutic Interchange and Generic Substitutions

Certain drugs will be covered only if step-therapy criteria are met. Enrollees may need to try one drug before taking another, or a medicine on the formulary must be tried before a nonformulary drug is approved by Humana.

Through a process of generic substitution, a pharmacy will provide, if available, a generic drug in place of a branded drug. Enrollees can expect the generic to produce the same effect and have the same safety profile as the branded drug. If a branded drug is requested when a generic equivalent is available, a prior-authorization request should be submitted. Additionally, if an enrollee has a drug allergy or intolerance, or a certain drug might not be effective and a nonformulary agent is requested, referred to as a therapeutic interchange, a prior-authorization request would be required.

Exceptions

Typically, our preferred drug list includes more than one drug for treating a particular condition. These different possibilities are called alternative drugs. If an alternative drug would be as effective as the drug requested and would not cause more side effects or other health problems, we would not approve a request for an exception.

You must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information when you ask for the exception.

If we deny your request for an exception, you can ask for a review of our decision by making an appeal. Please review the [Grievances & Appeals](#) section of this manual for details on how to submit appeals.

Medications Administered in the Provider Setting

Humana covers medications that are administered in a provider setting, such as a physician office, hospital outpatient department, clinic, dialysis center or infusion center. Prior authorization requirements exist for many injectables. Medicaid providers may:

- Obtain forms at [Humana.com/medPA](https://www.humana.com/medPA)

- Submit request by fax to 1-888-447-3430
- View preauthorization and notification lists at Humana.com/PAL

Network Pharmacies

Our pharmacy directory gives you a complete list of network pharmacies that have agreed to fill covered prescriptions for Humana enrollees. Providers and enrollees can access our Pharmacy Directory on our website at www.humana.com/finder/pharmacy/, and enrollees can use our Pharmacy Finder tool by logging in to MyHumana.com.

Copayment Requirements

Copayments may be required for some enrollees as indicated in the [Copayments](#) section of this manual.

Certain Humana Kentucky Medicaid enrollees are not required to make copayments for prescription drugs. Please check HealthNet to confirm copayments.

Tamper-resistant Prescriptions

In compliance with The Centers for Medicare & Medicaid Services, Kentucky Board of Pharmacy statutes, Regulations (902 KAR 55:105) and to prevent Medicaid prescription fraud, we ask prescribers and pharmacies to adhere to Kentucky Medicaid tamper-resistant prescription requirements on all hand-written and hard-copy prescriptions. Excluded from this requirement are faxed, electronic and phoned prescriptions.

To be considered “tamper-resistant,” prescriptions must contain one or more of the following industry-recognized features:

- Designed to prevent unauthorized copying of a completed or blank prescription form
- Designed to prevent erasure or modification of information written on the prescription by the prescriber
- Designed to prevent use of counterfeit prescription forms

Medicaid medications are reimbursable only if they include the following security features:

1. **Void pantograph** background screened at five percent in Pantone green shall be printed across the entire front of the prescription blank.
2. **Artificial watermark** placed on the backside of script so that it shall only be seen at a 45-degree angle. The watermark shall consist of the words “Kentucky Security Prescription,” and appear horizontally in a step-and-repeated format in five lines on the back of the prescription using 12-point Helvetica bold type style.
3. **Opaque Rx symbol** shall appear in the upper right-hand corner, 1/8 of an inch from the top of the prescription blank and 5/16 of an inch from the right side of the prescription blank. The symbol shall be 3/4 of an inch in size and disappear if the prescription is lightened.
4. **Six quantity check off boxes** printed on the form and the following quantities shall appear and be marked:

<input type="checkbox"/> 1-24	<input type="checkbox"/> 50-74	<input type="checkbox"/> 101-150
<input type="checkbox"/> 25-49	<input type="checkbox"/> 75-100	<input type="checkbox"/> 151 and over

5. The following statement shall be printed on the bottom of the prescription blank: **Prescription is void if more than one prescription is written per blank.**

6. **Refill options** shall appear below any logo on the left side of the prescription blank in the following order: Refill NR 1, 2, 3, 4 and 5, and be marked if the prescribed drug is a schedule III, IV or V controlled substance.
7. **Size of the prescription blank** shall be 4 1/4 inches high and 5 1/2 inches wide.
8. A prescription shall bear the preprinted, stamped, typed or manually printed name, address and telephone number of the prescribing practitioner.
9. A prescription blank for a controlled substance shall provide space for the patient's name and address, the practitioner's signature and the practitioner's Drug Enforcement Administration (DEA) registration number.
10. A prescription blank for a controlled substance shall not contain:
 - a. Advertisements on the front or back of the prescription blank
 - b. The preprinted name of a controlled substance

The written, typed or rubber-stamped name of a controlled substance until the prescription blank is signed, dated and issued to a patient.

Referrals and Prior Authorizations

This section describes our utilization management functions, the referral and prior-authorization processes and requirements for services provided to Humana enrollees.

Referrals

Humana allows direct access to specialized providers for enrollees in the following categories:

1. Enrollees with long-term, complex health conditions
2. Aged, blind, deaf or disabled persons
3. Enrollees identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring.

Humana enrollees may see any participating provider within our network, including specialists and inpatient hospitals. Enrollees may self-refer to any participating provider. PCPs do not need to arrange or approve these services for enrollees, as long as applicable benefit limits have not been exhausted.

Exceptions to this policy apply to enrollees who have been designated to participate in the Pharmacy Lock-in Program and/or Provider Lock-in Program. Please refer to the Lock-in Program section of the manual on Page 65.

If an enrollee requires medically necessary services from a non-participating provider the provider may need to call to obtain prior authorization.

Second Opinions for Nonparticipating Providers

Although Humana does not require referrals an enrollee may receive a second opinion. Providers or enrollees may request a second opinion at equal cost to the enrollee than if the service was obtained in network.

The following criteria should be used when selecting a provider for a second opinion:

- The provider must be a participating provider. If not, prior authorization must be obtained to send the patient to a nonparticipating provider. The provider must not be affiliated with the enrollee's PCP or the specialist practice group from which the first opinion was obtained.
- The provider must be in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

Release Due to Ethical Reasons

Providers are not required to perform any treatment or procedure that is contrary to the provider's conscience, religious beliefs or ethical principles, in accordance with 42 C.F.R 438.102. Please refer to Involuntary Dismissal on Page 13 for specific procedural requirements.

Prior Authorization

When prior authorization is requested for a service rendered in the same month, enrollee eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent upon enrollee eligibility on the date of service. Providers must verify eligibility on the date the service is to be rendered. Humana is not able to pay claims for services provided to ineligible enrollees. It is important to request prior authorization as soon as it is known that a service is needed.

All services that require prior authorization from Humana should be authorized before the service is delivered. Humana is not able to pay claims for services in which prior authorization is required but not obtained by the provider. Humana will notify you of prior-authorization determinations by a letter mailed to the provider address on file.

For standard prior-authorization decisions, Humana provides notice to the provider and enrollee as expeditiously as the enrollee's health condition requires, but no later than two business days following receipt of the request for service. The time frame for a standard authorization request may be extended up to 14 days if the provider or enrollee requests an extension, or if Humana justifies, in writing, to the Department a need for additional information and how the extension is in the enrollee's best interest. For cases in which a provider indicates, or Humana 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 if you believe the request is expedited.

Medicaid Services that Require Prior Authorization

- Physicians or other healthcare providers should review the "Kentucky Medicaid Prior Authorization List" online at [Humana.com/PAL](https://www.humana.com/PAL).

Requesting Prior Authorization

This section describes how to request prior authorization for medical and radiology services. For pharmacy prior authorization information, refer to the [Pharmacy](#) section of this manual.

Medical and Behavioral Health

Prior authorization for healthcare services can be obtained by contacting the Utilization Management department online or via email, fax, phone or mail:

- Visit the provider portal at www.Availity.com
- Access various prior authorization forms online at www.humana.com/provider/medical-resources/authorizations-referrals
- Email completed forms to CorporateMedicaidCIT@humana.com
- Fax completed prior authorization forms to 1-833-974-0059
- Call 1-888-285-1114

When requesting authorization, please provide the following information:

- Enrollee/patient name and Humana enrollee ID number
- Provider name, National Provider Identifier (NPI) and tax ID number (TIN) for ordering/servicing providers and facilities
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider, if applicable
- Clinical information to support the medical necessity of the service
- If the request is for inpatient admission for elective, urgent or emergency care, please include admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.
- If inpatient surgery is planned, please include the date of surgery, surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, all appropriate clinical review and anticipated discharge needs.
- If the request is for outpatient surgery, please include the date of surgery, surgeon and facility, diagnosis and procedure planned and anticipated discharge needs.

Authorization is not a guarantee of payment. Authorization is based on medical necessity and is contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Administrative denials may be rendered when applicable authorization procedures are not followed. Enrollees cannot be billed for services that are administratively denied due to a provider not following the requirements listed in this manual.

Retrospective Review

On written request, Humana 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 directly related to another service for which prior approval was obtained 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.
- Humana-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 will be upheld for the remainder of that prior-authorization approval time period.

Claims not meeting the necessary criteria as described in the policy document will be administratively denied.

When submitting a retro authorization request, the following documentation must be included:

- Patient name and Humana ID number
- Authorization number of the previously authorized service for the related request
- All supporting documentation related to the service

Requests for retrospective reviews can be faxed to 1-833-974-0059. Clinical information supporting the service must accompany the request.

Exceptions to this policy apply to enrollees designated to participate in the pharmacy and/or provider Lock-in Program.

Obtaining an Authorization to a Nonparticipating Provider

An authorization is required for enrollees to be evaluated or treated by nonparticipating providers. All providers (referring, treating, nonparticipating) must be enrolled with the KDMS as a Kentucky Medicaid-enrolled provider to receive payment for services rendered to a Kentucky Medicaid enrollee.

Utilization Management (UM)

Utilization Management helps maintain the quality and appropriateness of healthcare services provided to Humana enrollees. Utilization review determinations are based only on appropriateness of care and service and existence of coverage. Humana does not reward providers or our staff for denying coverage or services. There are no financial incentives for Humana staff to encourage decisions that result in underutilization. Humana does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition. Humana establishes measures designed to maintain quality of services and control costs that are consistent with our responsibility to our enrollees; we place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan, and applicable regulations, such as medical necessity; and place appropriate limits on a service for utilization control, provided the service furnished can reasonably be expected to achieve its purpose. Services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports.

The Utilization Management department performs all utilization management activities including prior authorization, concurrent review, discharge planning and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting, using the most appropriate resources. We also monitor the coordination of medical care to ensure its continuity. Referrals to the Humana Care Management team are made, if needed.

Humana completes an assessment of satisfaction with the UM process on an annual basis, identifying areas for improvement opportunities.

Criteria

Humana utilizes nationally recognized criteria to determine medical necessity and appropriateness of inpatient acute, behavioral health, rehabilitation and skilled nursing facility admissions. These criteria are designed to assist providers in identifying the most efficient quality care practices in use today. It is not intended to serve as a set of rules or as a replacement for a physician's medical judgment about individual patients.

Humana defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. Humana also has policy statements developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria for approval, the case is forwarded to a medical director for further review and determination.

Access to Staff

Providers may send an email to the Utilization Management staff with any UM questions.

- Medical health inquires: KYMCDMedicalUM@humana.com
- Behavioral health inquiries: KYMCDBehavioralHealthUM@humana.com

Please keep the following in mind when contacting UM staff:

- Staff are available Monday through Friday, 8 a.m. to 6 p.m. Eastern time.
- Staff can receive inbound communication regarding UM issues after normal business hours.
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff are available to respond to email inquiries regarding UM issues.
- Staff are accessible to answer questions about the UM process.
- In the best interest of our enrollees and to promote positive healthcare outcomes, Humana supports and encourages continuity of care and coordination of care between medical providers as well as between behavioral health providers.

Our enrollees' health is always our number one priority. Physician reviewers from Humana are available to discuss individual cases with attending physicians on request. Clinical criteria and clinical rationale or criteria used in making adverse determinations are available on request by contacting our Utilization Management department at:

- Medical health inquires: KYMCDMedicalUM@humana.com
- Behavioral health inquiries: KYMCDBehavioralHealthUM@humana.com

On request and at no cost to the provider, Humana will supply all documents, records and other information relevant to an adverse payment or coverage determination. If you would like to request a peer-to-peer discussion on an adverse determination with a Humana physician reviewer, please send an email to the addresses above within five business days of the determination.

Claims

Humana follows the claim reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. It is critical that all physician addresses and phone numbers on file with Humana are up to date to ensure timely claims processing and payment delivery.

Please note: Providers need to submit paper and electronic claims with ICD-10 codes as of Oct. 1, 2015. Failure to include ICD-10 codes on claims filed on or after Oct. 1, 2015 will result in claim denial.

Claim Submissions

Claims must be submitted within 180 calendar days of the date of service or discharge. We do not pay claims with incomplete, incorrect or unclear information. Providers have 180 calendar days from the date of service or discharge to submit a corrected claim or file a claim appeal.

Humana accepts electronic and paper claims. We encourage you to submit routine claims electronically to take advantage of the following benefits:

- Faster claims processing
- Reduced administrative costs
- Reduced probability of errors or missing information
- Faster feedback on claims status
- Minimal staff training and cost

All claims (electronic and paper) must include the following information:

- Patient (enrollee) name
- Patient address
- Insured's ID number: Be sure to provide the complete Humana enrollee ID for the patient
- Patient's birth date: Always include the enrollee's date of birth so we can identify the correct enrollee in case we have more than one enrollee with the same name
- Place of service: Use standard Centers for Medicare & Medicaid Services (CMS) location codes
- International Classification of Diseases, Tenth Edition, Clinical Modification (ICD-10-CM) diagnosis code(s)
- HIPAA-compliant Common Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code(s) and modifiers when modifiers are applicable
- Units, where applicable (anesthesia claims require number of minutes)
- Date of service: Please include dates for each individual service rendered - date ranges are not accepted, even though some claim forms contain from/to formats. Please enter each date individually.
- Prior authorization number, when applicable: A number is needed to match the claim to the corresponding prior authorization information. This is only needed if the service provided required a prior authorization.
- National Provider Identifier (NPI): Please refer to the [Location of Provider NPI, TIN and Enrollee ID Number section](#)
- Federal tax ID number or physician Social Security number: Every provider practice (e.g., legal business entity) has a different tax ID number
- Billing and rendering taxonomy codes that match the KDMS Master Provider List (MPL)
- Billing and rendering addresses that match the KDMS MPL

- Signature of physician or supplier: The provider's complete name should be included. If we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

For claim payment inquiries or complaints, please contact Humana at **1-800-448-6262 (1-800-4HUMANA)** or your provider contracting representative.

Please submit claim disputes to:

Humana Provider Correspondence
P.O. Box 14601
Lexington, KY 40512-4601

Electronic Funds Transfer/Electronic Remittance Advice

Electronic claims payment offers you several advantages over traditional paper checks:

- Faster payment processing
- Reduced manual processes
- Access to online or electronic remittance information
- Reduced risk of lost or stolen checks

With electronic funds transfer (EFT), your Humana claims payments are deposited directly in the bank account(s) of your choice. You also will be enrolled for our electronic remittance advice (ERA), which replaces the paper version of your explanation of remittance.

Fees may be associated with electronic transactions. Please check with your financial institution or merchant processor for specific rates related to EFT or credit card payments. Check with your clearinghouse for fees associated with ERA transactions.

There are two ways to enroll:

EFT/ERA Enrollment Through Humana

Get paid faster and reduce administrative paperwork with EFT and ERA.

Physicians and other healthcare providers can use Humana's ERA/EFT Enrollment tool on the Availity Provider Portal to enroll. To access this tool:

1. Sign in to the Availity Provider Portal at Availity.com (registration required).
2. From the Payer Spaces menu, select Humana.
3. From the Applications tab, select the ERA/EFT Enrollment app. (If you don't see the app, contact your Availity administrator to discuss your need for this tool.)

When you enroll in EFT, Humana claims payments are deposited directly in the bank account(s) of your choice.

EFT payment transactions are reported with file format CCD+, which is the recommended industry standard for EFT payments. The CCD+ format is a National Automated Clearing House Association (ACH) corporate payment format with a single, 80-character addendum record capability. The addendum record is used by the originator to

provide additional information about the payment to the recipient. This format is also referenced in the ERA (835 data file). Contact your financial institution if you would like to receive this information.

Please note: Fees may be associated with EFT payments. Consult your financial institution for specific rates.

The ERA replaces the paper version of the EOR. Humana delivers 5010 835 versions of all ERA remittance files that are compliant with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Humana utilizes Availity® as the central gateway for delivery of 835 transactions. You can access your ERA through your clearinghouse or through the secure provider tools available in the Availity provider portal, which opens a new window

Please note: Fees may be associated with ERA transactions. Consult your clearinghouse for specific rates.

Multipayer EFT/ERA Enrollment Through EnrollHub, a CAQH Solution

Practitioners who want to sign up for EFT payments from multiple health plans (Humana and others) can do so through EnrollHub, a Council for Affordable Quality Healthcare (CAQH) EFT/ERA Solution.

CAQH is a nonprofit alliance that creates solutions to streamline healthcare business processes. The alliance is known for CAQH ProView®, formerly the Universal Provider Datasource®, a solution that facilitates provider data collection and the credentialing process for more than 1.3 million practitioners.

With EnrollHub, you submit EFT enrollment information to CAQH online. CAQH verifies the information and then sends it to Humana and the other payers you select. These payers process your enrollment and begin sending electronic payments to your bank account. There is no enrollment cost for the provider.

Following the EFT enrollment process, you receive your remittance advice through a clearinghouse. When you enroll, you are prompted to designate the clearinghouse that should receive your ERA.

Please note: Fees may be associated with electronic transactions. Consult your financial institution for specific rates related to EFT and your clearinghouse for fees related to ERA.

Submitting Electronic Transactions

Provider Portal

Humana partnered with Availity to allow providers to reference enrollee and claim data for multiple payers using one login. Availity provides the following benefits:

- Eligibility and benefits
- Referrals and authorizations
- Claim status
- Claim submission
- Remittance advice

To learn more, call **1-800-282-4548** or visit www.Availity.com.

For information regarding electronic claim submission, contact your local provider contracting representative or visit Humana.com/providers and choose “Claims Resources” then “Electronic Claims & Encounter Submissions” or www.Availity.com.

Electronic Data Interchange (EDI) Clearinghouses

EDI is the computer-to-computer exchange of business data in standardized formats. EDI transmissions must follow the transaction and code set format specifications required by HIPAA. Our EDI system complies with HIPAA standards for electronic claim submission.

To submit claims electronically, providers must work with an electronic claim clearinghouse. Humana currently accepts electronic claims from Kentucky providers through the clearinghouses listed below. Please contact the clearinghouse of your choice to begin electronic claim submission.

When filing an electronic claim, you will need to utilize one of the following payer IDs:

- 61101 for fee-for-service claims
- 61102 for encounter claims

Following is a list of some of the commonly used claims clearinghouses and phone numbers:

Availity®	www.availity.com	1-800-282-4548
WayStar	www.waystar.com	1-877-494-7633
Trizetto	www.trizetto.com	1-800-556-2231
McKesson	www.mckesson.com	1-800-782-1334
Change Healthcare	www.changehealthcare.com	1-800-792-5256
SSI Group	www.thessigroup.com	1-800-881-2739

5010 Transactions

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic healthcare and pharmacy transactions. This action was taken in preparation to implement ICD-10 CM codes in 2015. The new standard is the HIPAA 5010 format.

The following transactions are covered under the 5010 requirement:

- 837 Claims encounters
- 276/277 Claim status inquiry
- 835 Electronic remittance advice
- 270/271 Eligibility
- 278 Prior-authorization requests
- 834 Enrollment

Procedure and Diagnosis Codes

HIPAA specifies that the healthcare industry use the following four code sets when submitting healthcare claims electronically:

- International Classification of Diseases, Tenth Edition, Clinical Modification (ICD-10-CM), available from the U.S. Government Printing Office by calling 1-202-512-1800 or faxing 1-202-512-2250 and from other vendors

- Current Procedural Terminology (CPT), available at <https://www.ama-assn.org/practice-management/cpt-current-procedural-terminology>
- HCFA Common Procedure Coding system (HCPCS), available at <http://www.cms.hhs.gov/default.asp>
- National Drug Codes (NDC), available at <http://www.fda.gov/>

Please note: Humana also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plan organizations. Local or proprietary codes are no longer allowed.

Unlisted CPT/HCPCS Codes

If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:

- A full, detailed description of the service provided
- A report, such as an operative report or a plan of treatment
- Other information that would assist in determining the service rendered

As an example, the code 84999 is an unlisted lab code that requires additional explanation.

National Provider Identifier (NPI), Tax Identification Number (TIN or tax ID) and Taxonomy

Your NPI and Tax ID are required on all claims, in addition to your provider taxonomy and specialty type codes (e.g., Federally Qualified Health Center, Rural Health Center and/or Primary Care Center) using the required claim type format (CMS-1500, UB-04 or Dental ADA) for the services rendered.

Effective Oct.1, 2013, KDMS requires all NPIs, billing and rendering addresses and taxonomy codes be present on its Master Provider List (MPL). Claims submitted without these numbers, or information that is not consistent with the MPL, will be rejected. Please contact your EDI clearinghouse if you have questions on where to use the NPI, tax ID or taxonomy numbers on the electronic claim form you are submitting.

Effective Aug. 1, 2018, KDMS updated billing provider taxonomy claim requirements for the following provider types:

- Federally Qualified Health Centers, provider type 31 with a specialty code 080
- Rural Health Centers, provider type 35

If billing providers have only one taxonomy linked to their KDMS MPL NPI, then their claims do not need to include taxonomy. Taxonomy is still required for the following:

- Billing providers who have multiple taxonomies linked to their NPI on the KDMS MPL
- All rendering providers

If your NPI and taxonomy codes change, please ensure you update your taxonomy information with Humana and KDMS' MPL. Please contact Humana Provider Service at **1-800-444-9137**, or your provider contracting representative, to update your demographic information. Submit changes to:

Humana Provider Correspondence
P.O. Box 14601
Lexington, KY 40512-4601

Location of Provider NPI, TIN and Enrollee ID Number

Humana accepts electronic claims in the 837 ANSI ASC X12N (005010A1) file format for both professional and hospital claims.

On 5010 (837P) Professional Claims:

The provider NPI should be in the following location:

- Medicaid: 2010AA Loop – Billing provider name
- 2010AA Loop – Billing provider name
- Identification code qualifier – NM108 = XX
- Identification code – NM109 = billing provider NPI
- 2310B Loop – rendering provider name
- Identification code qualifier – NM108 = XX
- Identification Code – NM109 = rendering provider NPI
- For form CMS-1500, the rendering provider taxonomy code in box 24J. ZZ qualifier in box 24I for rendering provider taxonomy

The billing provider TIN must be submitted as the secondary provider identifier using a REF segment, which is either the employer identification number for organizations (EIN) or the Social Security number (SSN) for individuals:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN
- The billing provider taxonomy code in box 33b

On 5010 (837I) Institutional Claims:

The billing provider NPI should be in the following location:

- 2010AA Loop – Billing provider name
- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = billing provider NPI

The billing provider tax ID number (TIN) must be submitted as the secondary provider identifier using a REF segment, which is either the EIN for organizations or the SSN for individuals:

- Reference identification qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference identification – REF02 = Billing provider TIN or SSN
- The billing taxonomy code goes in box 81

On all electronic claims:

The Humana enrollee ID number should go on:

- 2010BA Loop = Subscriber name
- NM109 = Enrollee ID number

Paper Claim Submissions

For the most efficient processing of your claims, Humana recommends you submit all claims electronically.

If you submit paper claims, please use one of the following claim forms:

- CMS-1500, formerly HCFA 1500 form — AMA universal claim form also known as the National Standard Format (NSF)
- CMS-1450 (UB-04), formerly UB92 form, for facilities

Paper claim submission must be done using the most current form version as designated by the CMS and the National Uniform Claim Committee (NUCC).

Detailed instructions for completing forms are available at the following websites:

- CMS-1500 Form Instructions: www.nucc.org
- UB-04 Form Instructions: <http://www.cms.hhs.gov/transmittals/downloads/R1104CP.pdf>

Please mail or fax all paper claim forms to Humana at the following address:

Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Humana uses optical/intelligent character recognition (OCR/ICR) systems to capture claims information to increase efficiency and to improve accuracy and turnaround time. We cannot accept handwritten claims or super bills.

Humana also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plan organizations. Local or proprietary codes are no longer allowed.

Instructions for National Drug Code (NDC) on Paper Claims

All of the following information is required for each applicable code required on a claim:

- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable), the 11-digit NDC (this excludes the N4 qualifier), a unit of measurement code (F2, GR, ML or UN are the only acceptable codes) and the metric decimal or unit quantity that follows the unit of measurement code
- Do not enter a space between the qualifier and the NDC or qualifier and quantity
- Do not enter hyphens or spaces with the NDC
- Use three spaces between the NDC and the units on paper forms

Tips for Submitting Paper Claims

- Electronic claims are generally processed more quickly than paper claims
- If you submit paper claims, we require the most current form version as designated by CMS and NUCC
- No handwritten claims or super bills, including printed claims with handwritten information, will be accepted
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website
- Fonts should be 10 to 14 point (capital letters preferred) in black ink
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form
- Federal tax ID number or physician SSN is required for all claim submissions
- All data must be updated and on file with the KDMS MPL, including TIN, billing and rendering NPI, addresses and taxonomy codes

- Coordination of Benefits (COB) paper claims require a copy of the Explanation of Payment (EOP) from the primary carrier

Out-of-Network Claims

Humana established guidelines for payments to out-of-network providers for preauthorized medically necessary services. These services will be reimbursed at 65% of the Kentucky Medicaid fee schedule.

The following are exceptions to the reimbursement guidelines and will be reimbursed at 90% of the Kentucky Medicaid fee schedule:

- Emergency care (nonparticipating professional and facility services provided to enrollees in an emergency room setting)
- Services provided for family planning
- Services for children in foster care

Claim Processing Guidelines

- Providers have 180 calendar days from the date of service or discharge to submit a claim. If the claim is submitted after 180 calendar days, the claim will be denied for timely filing.
- If an enrollee has other insurance and Humana is secondary, the provider may submit for secondary payment within 180 calendar days of the original date of service.
- If a provider does not agree with the decision on a processed claim, he or she has 180 calendar days from the date of service or discharge to file an appeal.
- On request and at no cost to the provider, Humana will supply all documents, records and other information relevant to an adverse payment or coverage determination.
- If the claim appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied.
- COB electronic claims require a copy of the primary carrier's payment information.
- If a claim is denied for COB information needed, the provider must submit the primary payer's EOB for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 60 days from the primary payer's EOB date. If a copy of the claim and EOB are not submitted within the required timeframe, the claim will be denied for timely filing.
- All claims for newborns must be submitted using the newborn's Humana ID number and Kentucky Medicaid ID number. Newborn infants shall be deemed eligible for Medicaid and automatically enrolled by the birthing hospital with Humana for 60 days. Do not submit newborn claims using the mother's identification numbers; the claim will be denied. Claims for newborns must include birth weight.
- Abortion sterilization and hysterectomy procedure claims submissions must have consent forms attached.
- Claims indicating that an enrollee's diagnosis was caused by the enrollee's employment will not be paid. The provider will be advised to submit the charges to Workers' Compensation for reimbursement.
- Skilled nursing and Hospice claims are processed the same. Both are billed on a UB-04 form. Revenue code 101 for skilled nursing claims for room and board will not be paid on the date of death. All other revenue codes will process according to guidelines outlined in KY MCD contract.
- Home health providers are required to bill the electronic HIPAA standard institutional claim transaction (837) or the provider can bill a paper form CMS-1450, also known as the UB-04. These claims are processed according to the claims guidelines and processing.

Claims Compliance Standards

Humana ensures their compliance target and turnaround times for electronic claims to be paid/denied comply within the below time frames:

- a. The Managed Care Plan pays 90% of all clean claims submitted within 30 days.
- b. The Managed Care Plan pays 99% of all claims submitted within 90 days.

Humana will ensure acknowledgment of all electronically submitted claims for services within the following time frames:

- Within 48 hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.
- Within 30 days after receipt of a clean claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.
- Pay or deny the claim within 90 days after receipt the claim.

For non-electronic claims Humana will ensure their compliance target and turnaround times comply with the following time frames:

- Within 20 days after receipt of the claim, provide acknowledgment of receipt of the claim to the provider or designee or provide the provider or designee with electronic access to the status of a submitted claim.
- Within 30 after receipt of the claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.
- Pay or deny the claim within 90 days after receipt of the claim.

Crossover Claims

Humana must receive the Medicaid Explanation of Benefits (EOB) with the claim. The claims adjuster reviews to ensure that all fields are completed on the EOB and determines the amount that should be paid out. Crossover claims should not be denied if received within 36 months from the date of service.

Claim Status

You can track the progress of submitted claims at any time through our provider portal at www.Availity.com. Claim status is updated daily and provides information on claims submitted in the previous 24 months. Searches by enrollee ID number, enrollee name and date of birth or claim number are available.

You can find the following claim information on the provider portal:

- Reason for payment or denial
- Check number(s) and date
- Procedure/diagnostic
- Claim payment date

Claims payments by Humana to providers are accompanied by an itemized accounting of the individual claims in the payment including, but not limited to, the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement and identification of Humana entity.

Humana extends each provider the opportunity for an in-person meeting with a Humana representative if a clean claim remains unpaid in violation of KRS 304.17A-700 to 304.17A-730. Additionally, the same opportunity is

extended to providers if a claim remains unpaid for more than 45 days after the date the claim was received by Humana and claim or claims amount, individually or in the aggregate, exceeds \$2,500.00.

Code Editing

Humana uses code editing software to review the accuracy of claim coding, such as the accuracy of diagnosis and procedure codes to ensure claims are processed consistently, accurately and efficiently.

Our code editing review may identify coding conflicts or inconsistent information on a claim. For example, a claim may contain a conflict between the patient's age and the procedure code, such as the submission for an adult patient of a procedure code limited to services provided to an infant. Humana's code editing software resolves these conflicts or indicates a need for additional information from the provider. Humana's code editing review evaluates the appropriateness of the procedure code only, but not the medical necessity of the procedure.

Humana provides notification of upcoming code editing changes. We publish new code editing rules and our rationales for these changes on the first Friday of each month at www.humana.com/provider/medical-resources/claims-payments/processing-edits.

Coding and Payment Policies

Humana strives to be consistent with KDMS, Medicaid and national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code/code set(s) submitted and related clinical standards for claims received electronically or as a hard copy.

We apply HIPAA standards to all electronically received claims. Accordingly, we accept only HIPAA-compliant code sets (i.e., HCPCS, CPT, and ICD-10).

In addition, CMS federal rules for Medicare and Medicaid coding standards are followed.

Finally, generally accepted commercial health insurance rules regarding coding and reimbursement also are used when appropriate. Humana strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

To determine unit prices for a specific code or service, please visit <https://chfs.ky.gov/agencies/dms/Pages/feesrates.aspx>.

Humana uses coding industry standards, such as the AMA CPT manual, NCCI and input from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including, but not limited to:

- Bundling issues
- Diagnosis to procedure matching
- Gender and age appropriateness
- Maximum units of a code per day
- Valid CPT/HCPCS code or modifier usage

Humana seeks to apply fair and reasonable coding edits. We maintain a provider appeals function that reviews, upon request, a claim denied based upon the use of a certain code, the relationship between two or more codes, unit counts or the use of modifiers. This review takes into consideration the previously mentioned KDMS, Medicaid, NCCI and national commercial standards when considering an appeal.

To ensure all relevant information is considered, appropriate clinical information should be supplied with the claim appeal. This clinical information allows the Humana appeals team to consider why the code set(s) and modifier(s) being submitted differ from the standards inherent in our edit logic. The clinical information may provide evidence that overrides the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Specific claims are subject to current Humana claim logic and other established coding benchmarks. Consideration of a provider's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

Coordination of Benefits (COB)

Humana collects COB information for our enrollees. This information helps us ensure that we pay claims appropriately and comply with federal regulations that Medicaid programs are the payer of last resort.

While we try to maintain accurate information at all times, we rely on numerous sources for information updated periodically, and some updates may not always be fully reflected on our provider portal. Please ask Humana enrollees for all healthcare insurance information at the time of service.

You can search for COB information on the provider portal by:

- Enrollee number
- Case number
- Medicaid number/MMIS number
- Enrollee name and date of birth

You can check COB information for enrollees active with Humana within the last 12 months.

Claims involving COB will not be paid until an EOB/EOP or EDI payment information file is received, indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full (i.e., \$0 balance) still must be submitted to Humana for processing due to regulatory requirements.

COB Overpayment

If a provider receives a payment from another carrier after receiving payment from Humana for the same items or services, this is considered an overpayment. Humana provides 30-days written notice to the provider before an adjustment for overpayment is made. If a dispute is not received from the provider, adjustments to the overpayment are made on a subsequent reimbursement. Providers also can issue refund checks to Humana for overpayments and mail them to the following address:

Humana Healthcare Plans
P.O. Box 931655
Atlanta, GA 31193-1655

Providers should not refund money paid to an enrollee by a third party.

Enrollee Billing

Providers should collect copayments from enrollees when applicable, as copayment amounts are subtracted from claim payments for services.

State requirements and federal regulations prohibit providers from billing Humana enrollees for medically necessary covered services except under very limited circumstances. Providers who knowingly and willfully bill an enrollee for a Medicaid-covered service shall be guilty of a felony and on conviction are fined, imprisoned or both, as defined in the Social Security Act.

Humana monitors this billing policy activity based on complaints of billing from enrollees. Failure to comply with regulations after intervention may result in both criminal charges and termination of your agreement with Humana.

Please remember that government regulations stipulate providers must hold enrollees harmless in the event that Humana does not pay for a covered service performed by the provider. Enrollees cannot be billed for services that are administratively denied. The only exception is if a Humana enrollee agrees in advance, in writing to pay for a non-Medicaid covered service. This agreement must be completed prior to providing the service and the enrollee must sign and date the agreement acknowledging his or her financial responsibility. The form or type of agreement must specifically state the services or procedures that are not covered by Medicaid.

Providers should call Enrollee/Provider Services at **1-800-444-9137** for guidance before billing enrollees for services.

Missed Appointments

In compliance with federal and state requirements, Humana enrollees cannot be billed for missed appointments. Humana encourages enrollees to keep scheduled appointments and to call to cancel ahead of time, if needed.

Enrollee Termination Claim Processing

From Humana to Another Plan

In the event of an enrollee's termination of enrollment with Humana into a different Medicaid plan, Humana may submit voided encounters to KDMS and notify providers of adjusted claims using the following process:

1. On daily receipt of the 834 eligibility file from KDMS, Humana identifies which enrollees received a retro-eligibility date and require termination of enrollment within the Humana claims payment system.
2. Humana initiates the enrollee termination process. This is completed within five business days of receipt of the 834 file.
3. Humana determines whether claims were paid for dates of service in which the enrollee was afterward identified as ineligible for Medicaid benefits with Humana. This process is completed within five business days.
4. Humana sends out a notice to each affected provider that recoupment of payment will occur for the claim(s) identified in the recoupment letter. The provider is given 30 calendar days to respond to the notice.
5. Once the 30 days expires, if the affected provider has not attempted to appeal the recoupment of payment or has not submitted a refund check before 30 calendar days have expired, Humana adjusts the payment(s) for the affected claims listed in the notice letter. This takes place within 10 business days.
6. The provider receives an EOP reflecting the funds recouped. This takes place within five business days of completion of payment adjustment(s).
7. After the recoupment receives a processed date stamp, a voided encounter for the affected claims is submitted to KDMS within ten business days, assuming the original submitted encounter was previously accepted. Please note that if the original encounter was denied or rejected by KDMS, a void does not need to occur.

8. On successful completion of the encounter-void process, affected providers are sent a courtesy letter informing them that the original payment was successfully cleared from the KDMS system and that they can proceed in billing the claim(s) with the enrollee's current active Medicaid plan. The courtesy letter is sent within five business days. Please note that if the KDMS did not accept the voided encounter, the process may be delayed an additional ten business days.

If the provider experiences continued issues receiving payment from another Medicaid plan within 60 days of the issued EOP reflecting recoupment of payments and the issued courtesy letter, Humana encourages providers to contact the enrollee's current Medicaid Managed Care Plan for the claim(s) dates of service.

From Another Plan to Humana

If an enrollee was previously enrolled with another Medicaid plan and is now eligible with Humana, providers are required to submit a copy of the EOP reflecting recoupment of payment and documentation from the previous managed care organization (MCO) to validate the original encounter has been voided and accepted by KDMS.

These items are used to support overriding timely filing, if eligible. If a claim has exceeded timely filing due to retro-eligibility from another Medicaid plan, the provider has 90 days from the date of the accepted voided encounter to submit the claim to Humana to avoid timely filing denials.

Grievances and Appeals

Provider Grievance and Appeals

You have the right to file a grievance or appeal with Humana regarding a healthcare service, claim for reimbursement, provider payment or a contractual issue.

A grievance is a complaint. An appeal is a request to change a previous decision made by Humana. For purposes of this section, coverage denial is Humana's determination that a service, treatment, drug or service is specifically limited or excluded under the enrollee's specified health benefit plan. When a coverage denial is involved, you may request an internal appeal.

As a provider, you can file grievances and appeals on your own behalf. You can file an appeal on behalf of an enrollee if you have the enrollee's written consent. Humana ensures that no punitive or retaliatory action is taken against an enrollee or provider who files a grievance or appeal or a provider who supports an enrollee's grievance or appeal.

Internal Appeals:

You may file a grievance or appeal related to the reduction or denial of a claim within 60 days of receipt of notification that payment for a submitted claim has been reduced or denied.

Effective Jan. 4, 2019, if a provider does not agree with the decision on a processed claim, the provider has 180 calendar days from the date of the **original claim submission denial** to file an appeal. If the claim appeal is not submitted in the required time frame, the claim is not considered and the appeal is denied. If the appeal is denied, you are notified in writing. If the appeal is approved, payment shows on your EOP. Humana resolves provider grievances and appeals within 30 calendar days of receipt of the appeal request. Humana may request a 14-day extension from you to resolve your grievance or appeal.

Internal appeal determination letters include:

1. A statement of the specific medical and scientific reasons for denying coverage or identifying that provision of the schedule of benefits or exclusions that demonstrates coverage is not available
2. The state of licensure, medical license number and the title of the person making the decision
3. Except for retrospective review, a description of alternative benefits, services or supplies covered by the health benefit plan, if any
4. Instructions for initiating an external review of an adverse determination, or filing a request with KDMS if a coverage denial is upheld by Human on internal appeal

Please note: If you believe a claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. You do not need to file an appeal. Providers have 180 calendar days from the date of service or discharge to submit a corrected claim.

Verbal Submission:

For all inquiries, including complaints, please contact Humana Customer Service at 1-800-444-9137. Based on the type of issue or complaint, your inquiry is reviewed by a Humana associate with the designated authority to resolve your issue or complaint.

Written Submission:

The provider can submit in writing to:

Humana Provider Correspondence
Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax: 1-800-949-2961

Digital Submission:

Providers can submit encrypted grievance or appeal supporting documentation online via Availity. Grievance and/or appeal status also can be checked via Availity.

Expedited Process:

You may request an expedited appeal of either an adverse determination or a coverage denial and receive a decision no later than three business days after receipt of the request. An expedited appeal is deemed necessary when a covered person is hospitalized or if you believe the standard appeal timeframe would result in:

1. Placing the health of the enrollee (or pregnant woman and the unborn child) in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of a bodily organ or part

External Independent Reviews:

Humana complies with all rights and requirements conferred to providers, pursuant to 907 KAR 17:035.

- After a provider exhausts all internal appeal rights, the provider can request an external independent review. A provider cannot request an external independent review if the enrollee has exercised his/her right for a state hearing.
- The provider must submit a request for an external independent review within 60 calendar days of receiving final decision on the internal appeal.

- After Humana receives a request from a provider for an external independent review, Humana sends the provider an acknowledgement letter within five business days.
- The external independent review entity issues a final decision with 30 calendar days of receiving the review packet from Humana.
- Humana and the provider both have the right to appeal the decision of the external independent review entity to a state hearing proceeding. The request for a state hearing must be sent to the state within 30 calendar days of the external independent review entity's decision.

KDMS Request for Review of Coverage Denials:

If you have exhausted Humana's internal appeals process, including review by an external third party, you may appeal the third party's final decision to the Cabinet for Health and Family Services Division of Administrative Hearings.

In this case, the Cabinet for Health and Family Services Division of Administrative Hearings requests Humana review and respond back to the Commonwealth within 10 business days of receipt of the request. Humana then replies to KDMS with:

1. Confirmation of whether the enrollee was covered at the time the service was rendered
2. Confirmation of whether you have exhausted your rights under Humana's appeal process
3. The reason for the coverage denial

Enrollee Grievances, Appeals and State Fair Hearing Requests

Grievances and appeals are not the same thing. At any time during the grievance or appeal process you can request copies of the documents pertaining to your case free of charge by contacting Customer Care.

Provider Roles and Responsibilities

Provider Responsibilities

Participating providers are expected to make daily visits to their patients who are admitted as inpatients to an acute care facility or arrange for a colleague to visit. Participating PCPs are expected to have a system in place for following up with patients who miss scheduled appointments.

Participating providers are expected to treat enrollees with respect. Humana enrollees should not be treated differently than patients with other healthcare insurance. Please reference the Enrollee Rights and Responsibilities section of this manual.

Humana expects participating providers to verify enrollee eligibility and ask for all his or her healthcare insurance information before rendering services, except in an emergency. You can verify enrollee eligibility on HealthNet and obtain information for other healthcare insurance coverage we have on file by accessing the provider portal at [Availity.com](https://www.availity.com).

Provider Status Changes

Advance written notice of status changes, such as a change in address, phone or adding or deleting a provider at your practice, helps us keep our records current. This information is critical to process your claims. In addition, it ensures our provider directories are up to date and reduces unnecessary calls to your practice. This information also is reportable to Medicaid and Medicare.

Primary Care Providers (PCPs)

All Humana enrollees choose or are assigned to a PCP on enrollment in the plan. PCPs help facilitate a “medical home” for enrollees. This means that PCPs help coordinate healthcare for the enrollee and provide additional health options to the enrollee for self-care or care from community partners. PCPs also are required to know how to screen and refer enrollees for behavioral health conditions. Please refer to the Behavioral Health and Substance Use Services section for more information.

Enrollees select a PCP from our health plan’s provider directory. Enrollees have the option to change to another participating PCP as often as needed. Enrollees initiate the change by calling Customer Service. PCP changes are effective on the first day of the month following the requested change.

Education

Humana will conduct an initial educational orientation for all newly contracted providers within 30 days of activation. Providers receive periodic and/or targeted education as needed.

Roles and Responsibilities

Primary care providers are:

- Responsible for supervising, coordinating and providing initial and primary care to enrollees
- Responsible for initiating referrals for specialty care
- Responsible for maintaining the continuity of patient care 24 hours per day, seven days a week
- Responsible for holding hospital admitting privileges or a formal referral agreement with a primary care provider who has hospital admitting privileges

In addition, Humana PCPs play an integral part in coordinating healthcare for our enrollees by providing:

- Availability of a personal healthcare practitioner to assist with coordinating an enrollee's overall care, as appropriate for the enrollee
- Continuity of the enrollee's total healthcare
- Early detection and preventive healthcare services
- Elimination of inappropriate and duplicate services

PCP care coordination responsibilities include, at a minimum, the following:

- Treating Humana enrollees with the same dignity and respect afforded to all patients – including standards of care and hours of operation
- Maintaining continuity of the enrollee's healthcare
- Identifying the enrollee's health needs and taking appropriate action
- Providing phone coverage for handling patient calls 24 hours a day, seven days a week
- Making referrals for specialty care and other medically necessary services, both in and out-of-network when such services are not available within the Humana network
- Following all referral and prior-authorization policies and procedures as outlined in this manual
- Complying with the quality standards of Humana and the Commonwealth of Kentucky as outlined in this manual
- Discussing advance medical directives with all enrollees as appropriate
- Providing 30 days of emergency coverage to a patient dismissed from the practice
- Maintaining clinical records, including information about pharmaceuticals, referrals, inpatient history and documentation of all PCP and specialty care services, etc., in a complete and accurate medical record that meets or exceeds the KDMS' specifications
- Obtaining patient records from facilities visited by Humana patients for emergency or urgent care if notified of the visit
- Ensuring demographic and practice information is up to date for directory and enrollee use
- Referring enrollees to behavioral providers and arranging appointments, when clinically appropriate
- Assisting with coordination of the enrollee's overall care, as appropriate for the enrollee
- Serving as the ongoing source of primary and preventive care, including Early and Periodic Screening, Diagnostic and Treatment (ESPDT) for persons younger than 21
- Recommending referrals to specialists, as required
- Participating in the development of care management care treatment plans and notifying Humana of enrollees who may benefit from care management
- Maintaining formalized relationships with other PCPs to refer their enrollees for after-hours care, during certain days and for certain services or other reasons to extend their practices

Participating providers must meet the following Kentucky Medicaid contractual requirements related to acceptable after-hours access:

Acceptable:

- 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 has 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 is able to contact the PCP or another designated medical practitioner within a maximum of 30 minutes.

Unacceptable:

- Office phone is only answered during office hours.
- Office phone is answered after hours by a recording that tells patients to leave a message.
- Office phone is answered after hours by a recording that directs patients to go to the emergency room for services needed.
- After-hours calls not returned within 30 minutes.

Key Contract Provisions

To make it easier for you, we outlined key components of your contract with Humana.

These key components strengthen our relationship with you and enable us to meet or exceed our commitment to improve the healthcare and well-being of our enrollees. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of our enrollees. Unless otherwise specified in a provider's contract, the following standard key contract terms apply.

Participating providers are responsible for:

- Providing Humana with advance written notice of intent to terminate an agreement with us. This must be done 90 days prior to the date of the intended termination and submitted on your organization's letterhead.
- Sending the required 60-day notice if you plan to close your practice to new patients. If we are not notified within this time period, you will be required to continue accepting Humana enrollees for a 60-day period following notification.
- Providing 24-hour availability to your Humana-covered patients by telephone (for PCPs only). Whether through an answering machine or a taped message used after hours, patients should be provided the means to contact their PCP or a back-up physician to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up physician and only recommends emergency room use for after hours.
- Submitting claims and corrected claims within 180 calendar days of the date of service or discharge.
- Filing appeals within 180 calendar days of the date of service or discharge.
- Keeping all demographic and practice information up to date.

Our agreement also indicates that Humana is responsible for:

- Paying 90 percent of clean claims within 30 days of receipt.
- Providing you with an appeals procedure for timely resolution of requests to reverse a Humana determination regarding claim payment. Our appeal process is outlined in the Grievances and Appeals section of this manual.
- Offering a 24-hour nurse triage phone service for enrollees to reach a medical professional at any time with questions or concerns.

- Coordinating benefits for enrollees with primary insurance up to our allowable rate for covered services. If the enrollee's primary insurance pays a provider equal to or more than the Humana fee schedule for a covered service, Humana does not pay any additional amount. If the enrollee's primary insurance pays less than the Humana fee schedule for a covered service, Humana reimburses the difference up to the Humana allowable rate.

These are just a few of the specific terms of our agreement. In addition, we expect participating providers to follow industry standard-practice procedures even though they may not be spelled out in our provider agreement.

Advance Directives

PCPs have the responsibility to discuss advance medical directives with adult enrollees who are 18 or older and who are of sound mind at the first medical appointment. The discussion should subsequently be charted in the permanent medical record of the enrollee. A copy of the advance directive should be included in the enrollee's medical record inclusive of other mental health directives.

The PCP should discuss potential medical emergencies with the enrollee and document that discussion in the enrollee's medical record.

Kentucky Health Information Exchange

Humana encourages all providers in our network to establish connectivity with the Kentucky Health Information Exchange (KHIE) and recommends hospitals submit Admission, Discharge and Transfer messages (ADT) to KHIE. If providers do not have an electronic health record, Humana encourages the providers to sign a participation agreement with KHIE and sign up for Direct Secure Messaging services so clinical information can be shared securely with other providers in their community of care. Please note that the KDMS may, at its discretion, mandate provider participation with at least 90 days written notice to Humana.

The KHIE is an interoperable network in which participating providers with certified electronic health record technology (CEHRT) can access, locate and share needed patient health information with other providers, at the point of care.

The Health Information Exchange provides a common, secure electronic information infrastructure that meets national standards to ensure interoperability across various health systems, while affording providers the functionality to support preventive health and disease management.

KHIE serves as the intermediary for public health reporting in the Commonwealth of Kentucky and works with providers and hospitals. Ultimately, KHIE strives to improve care coordination and overall health outcomes while facilitating the adoption, integration and the meaningful use of CEHRT.

Visit the KHIE website and learn how to make the KHIE Connection at www.khie.ky.gov/Pages/index.aspx.

Americans with Disabilities Act (ADA)

All Humana-contracted healthcare providers must comply with the Americans with Disabilities Act (ADA), as

well as all applicable state and/or federal laws, rules and regulations. More details are available in the Humana provider agreement under “Compliance with Regulatory Requirements.”

Humana develops individualized care plans that take into account enrollees’ special and unique needs. Healthcare providers with patients who require interpretive services may call 1-877-320-2233 or email accessibility@humana.com with date, time, provider phone number and location for appointment. Please do not include any patient health information. This is not needed when emailing.

If you have enrollees who need interpretation services, they can call the number on the back of their enrollee ID cards or visit www.humana.com/accessibility-resources.

Cultural Competency

Participating providers are expected to provide services in a culturally competent manner which includes, but is not limited to, removing all language barriers to service and accommodating the special needs of the ethnic, cultural and social circumstances of the patient.

Participating providers must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973.

Humana recognizes cultural differences and the influence that race, ethnicity, language and socioeconomic status have on the healthcare experience and health outcomes. It is committed to developing strategies that eliminate health disparities and address gaps in care.

A report by the Institute of Medicine in 2002 confirmed the existence of racial and ethnic disparities in Healthcare. “Unequal Treatment” found racial differences in the type of care delivered across a wide range of healthcare settings and disease conditions, even when controlling for socioeconomic status factors such as income and insurance coverage. Annual national Healthcare disparities reports from the Agency for Healthcare Research and Quality (AHRQ) confirm that these gaps persist in the American healthcare system.

Communication is paramount in delivering effective care. Mutual understanding may be difficult during cross-cultural interaction between patients and providers. Some disparities may be attributed to miscommunication between providers and patients, language barriers, cultural norms and beliefs and attitudes that determine health-care-seeking behaviors. Providers can address racial and ethnic gaps in healthcare with an awareness of cultural needs and improving communication with a growing number of diverse patients.

Humana offers a number of initiatives to deliver services to all enrollees regardless of ethnicity, socioeconomic status, culture and primary language. These include language assistance services, race and ethnicity data collection and analysis, internal staff training and Spanish resources. Other initiatives give providers resources and materials, including tools from health-related organizations, that support awareness of gaps in care and information on culturally competent care.

A copy of Humana’s Cultural Competency Plan is provided at no charge to the provider. Humana’s Cultural Competency Plan can be viewed at www.humana.com/provider/news/language-assistance-program. To request a paper copy, please contact Humana Provider Service at 1-800-444-9137.

Marketing Materials

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

Provider Training

Providers are expected to adhere to all training programs identified by the contract and Humana as compliance-based training. This includes agreement and assurance that all affiliated participating providers and staff enrollees are trained on the identified compliance material.

As part of training requirements, providers must complete annual compliance training on the following topics:

- Medicaid provider orientation training
- Compliance and fraud, waste and abuse
- Cultural competency
- Health, safety and welfare (Abuse, neglect and exploitation)

All new providers also receive Humana’s Medicaid Provider Orientation. Providers also must complete annual required training on compliance and fraud, waste and abuse to ensure specific controls are in place for the prevention and detection of potential or suspected fraud and abuse as required by s. 6032 of the federal Deficit Reduction Act of 2005.

Providers and enrollees of their office staff can access these online training modules 24 hours a day, seven days a week at www.humana.com. Sign in with your existing user ID and password. If your organization is not yet registered, registration can be completed immediately. Choose “Resources,” locate the “Compliance” section and then choose “Required Compliance Events.”

Additional provider training: Visit Humana.com/providers and choose “Web-based Training Schedule” under “Critical Topics.”

Enrollee Rights and Responsibilities

As a Humana provider, you are required to respect the rights of our enrollees. Humana enrollees are informed of their rights and responsibilities via their enrollee handbook. The list of our enrollee’s rights and responsibilities is below.

All enrollees are encouraged to take an active and participatory role in their own health and the health of their family. Enrollees have the right:

- To receive all services that the plan must provide and to get them in a timely manner
- To get timely access to care without communication or physical access barriers
- To have reasonable opportunity to choose the provider that gives you care whenever possible and appropriate
- To choose a PCP and change to another PCP in Humana’s network. We send the enrollee something in writing that says who the new PCP is when a change is made.

- To be able to get a second opinion from a qualified provider in or out of our network. If a qualified provider is not able to see the enrollee, we must set up a visit with a provider not in our network.
- To get timely access and referrals to medically indicated specialty care
- To be protected from liability for payment
- To receive information about your health. It also may be given to someone the enrollee has legally approved to have the information, or it may be given to someone the enrollee said should be reached in an emergency when it is not in the best interest of the enrollee's health to give it to them.
- To ask questions and get complete information about the enrollee's health and treatment options in a way they can follow. This includes specialty care.
- To have a candid discussion of any appropriate or medically necessary treatment options for the enrollee's condition, regardless of cost or benefit coverage.
- To take an active part in decisions about the enrollee's health care unless it is not in his/her's best interest.
- To say yes or no to treatment or therapy. If the enrollee says no, the doctor or Humana must explain what could happen. They will put a note in the enrollee's medical record.
- To be treated with respect, dignity, privacy, confidentiality, accessibility and nondiscrimination
- To have access to appropriate services and not be discriminated against based on health status, religion, age, gender or other bias
- To be sure that others cannot hear or see the enrollee when receiving medical care
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease or revenge, as specified in federal laws
- Receive information in accordance with 42 CFR 438.10
- Be furnished health care services in accordance with 42 CFR 438.206 through 438.210
- Any Indian enrolled with Humana eligible to receive services from a participating Indian Health Service, Tribally Operated Facility/Program and Urban Indian Clinic (I/T/U) provider or an I/T/U primary care provider can receive services from that provider if part of Humana's network.
- To get help with the enrollee's medical records in accordance with applicable federal and state laws.
- To be sure that the enrollee's medical records are kept private.
- To ask for and receive one free copy of his/her medical records and to be able to ask that his/her health records be changed or corrected if needed. More copies are available to enrollees at cost.
- To say yes or no to having information about the enrollee given out unless Humana must provide it by law
- To receive all written enrollee information:
 - a. At no cost to the enrollee
 - b. In the prevalent non-English languages of enrollees in our service area,
 - c. In other ways to help with the special needs of enrollees who have trouble reading the information for any reason
- To get help from us and our providers if the enrollee does not speak English or needs help to understand information. Enrollees can get the help free of charge.
- To get help with sign language if the enrollee is hearing impaired
- To be told if a healthcare provider is a student and be able to refuse his or her care
- To be told if care is experimental and be able to refuse to be part of the care
- To know that Humana must follow all federal, state and other laws about privacy that apply

- If you are a female, to be able to go to a woman's health provider in our network for covered woman's health services.
- To file an appeal or grievance (complaint) or request a state fair hearing.
 - a. Enrollees also can get help with filing an appeal or a grievance. They can ask for a state fair hearing from Humana and/or the KDMS. To make advance directives, such as a living will, see page 68.
- To contact the Office of Civil Rights at the following address with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services:
 - Office for Civil Rights
 - Sam Nunn Atlanta Federal Center, Suite 16T70
 - 62 Forsyth St., S.W.
 - Atlanta, GA 30303-8909
 - Phone: 1-800-368-1019, TDD: 1-800-537-7697
 - Fax: 1-202-619-3818
- To receive information about Humana, our services, our practitioners and providers and enrollee rights and responsibilities.
- To make recommendations to our enrollee rights and responsibility policy.
- If Humana is unable to provide a necessary and covered service in our network, we cover these services out of network. We do this for as long as we cannot provide the service in network. If an enrollee is approved to go out of network, this is his/her right as an enrollee. There is no cost to the enrollee.
- To be free to carry out enrollee rights and know that Humana or our providers cannot hold this against you.

Humana may not discriminate on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services in the receipt of health services.

Humana enrollees are also informed of the following responsibilities:

- Know your rights.
- Follow Humana and Kentucky Medicaid policies and procedures.
- Know about your service and treatment options.
- Take an active part in decisions about your personal health and care and lead a healthy lifestyle.
- Understand as much as you can about your health issues.
- Take part in reaching goals that you and your healthcare provider agree upon.
- Let us know if you suspect health care fraud or abuse.
- Let us know if you are unhappy with us or one of our providers.
- If you file an appeal with us, put the request in writing.
- Use only approved providers.
- Report any suspected fraud, waste or abuse using the information provided in this manual.
- Keep scheduled doctor visits. Be on time. If you have to cancel, call 24 hours in advance.
- Follow the advice and instructions for care you have agreed upon with your doctors and other healthcare providers.

- Always carry your ID card. Show it when receiving services.
- Never let anyone else use your ID card.
- We want to make sure we are always able to connect with you about your care.
- Let us know of a name, address or phone number change, or a change in the size of your family.
- Let us know about births and deaths in your family. We don't want to lose you as an enrollee, so it is really important to let us know. It is also a good idea to tell your local Department for Community Based Services (DCBS) any about any changes. To find the nearest DCBS office, visit the website at <https://chfs.ky.gov/agencies/dcbs/Pages/default.aspx>. Or call the ombudsman toll-free at 1-855-306-8959
- Call your PCP after going to an urgent care center, after a medical emergency or after getting medical care outside of Humana's service area.
- Let Humana and the DCBS know if you have other health insurance coverage.
- Provide the information that Humana and your health care providers need in order to care for you.
- Report suspected fraud and abuse (see Page 76).

Personally Identifiable Information and Protected Health Information

In the day-to-day business of patient treatment, payment and healthcare operations, Humana and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide how PII is appropriately protected when stored, processed and transferred in the course of conducting normal business. As a provider, you should be taking measures to secure your patients' data.

You also are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to secure all protected health information (PHI) related to your patients. There are many administrative, physical and technical controls you should have in place to protect all PII and PHI.

Here are some important places to start:

- Utilize a secure message tool or service to protect data sent by email
- Have policies and procedures in place to address the protection of paper documents containing patient information, including secure storage, handling and destruction of documents
- Encrypt all laptops, desktops and portable media such as CD-ROMs and USB flash drives that may potentially contain PHI or PII

Enrollee Privacy

The HIPAA Privacy Rule requires health plans and covered healthcare practitioners to develop and distribute a notice that provides a clear, user-friendly explanation of individuals' rights with respect to their personal health information, as well as the privacy practices of health insurance plans and healthcare practitioners.

KDMS provides a privacy notice to Medicaid enrollees. Access the HIPAA Information page at www.kymmis.com/kymmis/HIPAA/. The notice informs enrollees about how KDMS is legally required to protect the privacy of enrollee data.

As a provider, please follow the HIPAA regulations and make only reasonable and appropriate uses and disclosures of protected health information for treatment, payment and healthcare operations.

Enrollee Consent to Share Health Information

Consent is the enrollee's written permission to share their information. Not all disclosures require the enrollee's permission. The following are consent requirements that pertain to Sensitive Health Information (SHI) and substance-use disorder (SUD) treatment:

- SHI is defined by the state (e.g., HIV/AIDS, mental health, sexually transmitted diseases).
- SUD [42 CFR Part 2](http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr2_main_02.tpl) (Part 2), at www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr2_main_02.tpl, pertains to federal requirements that apply to all states.

While all enrollee data is protected under the HIPAA Privacy Rules, Part 2 provides more stringent federal protections in an attempt to protect individuals with substance-use disorders who could be subject to discrimination and legal consequences in the event their information is inappropriately used or disclosed. The state requirements provide more stringent protections for the sharing of certain information determined to be SHI.

When consent is on record, Humana displays all enrollee information on the provider portal at **Availity.com** and any health information exchanges. Please explain to your patients that if they do not consent to let Humana share this information, the providers involved in their care may not be able to effectively coordinate their care. When an enrollee does not consent to share this information, a message displays on the provider portal to indicate that all of the enrollee's health information may not be available to all providers.

Pharmacy Lock-in Program

The lock-in program is designed for individuals enrolled in Medicaid in Kentucky who need help managing their use of prescription medications. It is intended to limit overuse of benefits and reduce unnecessary costs to Medicaid while providing an appropriate level of care for the enrollee. Humana enrollees who meet the program criteria will be locked in to one pharmacy.

The Lock-in program is required by KDMS.

Humana monitors claim activity for signs of misuse or abuse in accordance with state and federal laws. If a review of an enrollee's claim activity reveals an unusually large number of controlled substance prescriptions or or misuse of prescriptions, the enrollee is considered a candidate for the lock-in program.

Enrollees identified to be enrolled in the lock-in program receive written notification from Humana, along with the designated lock-in pharmacy's information and the enrollee's right to appeal the plan's decision.

Enrollees are initially locked-in for a total of 12 months, during which the enrollee can only request a change from their designated lock-in provider one time.

Following the enrollee's 12-month enrollment, a utilization review is conducted to determine the enrollee's continued need for the program. Once the restriction has been lifted, the enrollee is placed on a six month follow-up for review of prescription history to determine if the lock-in should be reinstated for an additional period of 24 months.

Referrals

Humana monitors enrollees' claim history and utilization to identify enrollees who may benefit from enrollment in the Pharmacy Lock-in Program. Enrollees also may be referred for evaluation to participate in the lock-in

program by their PCP or a specialist who is caring for them by calling 1-888-285-1121. Excluded from enrollment in the lock-in program are enrollees who:

- Reside in a facility reimbursed pursuant to 907 KAR 1:025 or 1:065 or in a personal care home
- Are younger than 18
- Receive services through a home- and community-based waiver program or hospice services
- Utilize Medicaid services at a frequency that was medically necessary to treat a complex, life-threatening medical condition

Quality Improvement

On request, Humana makes available to providers information about its quality management and quality improvement program and a summary report on Humana's progress in meeting quality improvement goals. To obtain a copy, call the local Humana market office's Quality Management Department or call Enrollee/Provider Services at **1-800-444-9137**.

Quality Management Activities: Participating providers agree to allow and assist Humana with its performance of the following quality management activities:

- Medical Records Reviews – Conducted to meet requirements of accrediting agencies and federal and state law requirements. Annually, Humana may review a sample of clinical records for Humana enrollees. Humana does not review all records and is not responsible for assuring the adequacy or completeness of records.
- Healthcare Effectiveness Data and Information Set (HEDIS®) – HEDIS is a set of performance measures. Humana may conduct medical record reviews to identify gaps in care for Humana enrollees. HEDIS now includes care coordination measures for enrollees transitioning from a hospital or emergency department to home for which hospitals and providers have additional responsibilities. In addition to medical record reviews, information for HEDIS is gathered administratively via claims, encounters and submitted supplemental data. There are two primary routes for supplemental data:
 - Nonstandard supplemental data involves directly submitted, scanned images (e.g. .pdf documents) of completed attestation forms and medical records. Nonstandard data also can be accepted electronically via a proprietary Electronic Attestation Form (EAF) or Practitioner Assessment Form (PAF). Submitted nonstandard supplemental data is subject to audit by a team of nurse reviewers before ending a HEDIS improvement opportunity.
 - Standard supplemental data flows directly from one electronic database (e.g. population health system, EMR) to another without manual interpretation. Therefore, standard supplemental data is exempt from audit consideration. Standard supplemental data can be accepted via HEDIS-specific custom reports extracted directly from the provider's EMR or population health tool and is submitted to Humana via either secure email or FTP transmission. We also accept lab data files in the same way. Humana partners with various EMRs to provide enrollee summaries and detail reports and to automatically retrieve scanned charts.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) – The CAHPS survey includes several measures that reflect enrollee satisfaction with the care and service provided by the physician.
- Humana is rated on an annual basis by the government on multiple measures that fall under HEDIS and CAHPS. Each year surveys are sent to our enrollees that ask multiple questions of how you, the physician, and Humana are performing. It is imperative that we partner to strive for excellence in these areas. For further information, please visit www.cms.gov.
- Occurrences and Adverse Events Reporting – Unexpected occurrences and adverse events involving enrollees are reported to the Quality Management Department by providers, precertification nurses and

care managers. Cases are reviewed according to Humana's Quality Management and, as applicable, peer-review process, as required by law and accrediting agencies.

- Enrollee Complaints – Enrollee complaints and grievances pertaining to quality of care and concerns may be referred to the Quality Operations Department for review.
- Humana participates in the following KDMS requirements:
 - Maintain a health information system that collects, integrates, analyzes and reports data necessary to implement the quality improvement program.
 - Initiate performance improvement projects (PIPs) that address those areas that have been identified as healthcare priorities for our enrollees, or topics that are mandated by KDMS.

Quality Improvement Requirements

Humana monitors and evaluates provider quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to enrollees using the following methods:

Performance improvement projects (PIPs) – Ongoing measurements and interventions, significant improvement to 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 audits – Medical record reviews to evaluate patterns of complaints regarding poor quality of service, poor quality outcomes and adherence to enrollee record documentation standards.

Performance measures – Data collected on patient outcomes as defined by HEDIS or otherwise defined by the agency.

Surveys – CAHPS

Peer review – Review of provider's practice methods and patterns to determine appropriateness of care.

Standards for enrollee records:

1. Enrollee/patient identification information on each page;
2. 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 telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information;
3. Date of data entry and date of encounter;
4. Provider identification by name;
5. Allergies, adverse reactions and all known allergies noted in a prominent location;
6. 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 chickenpox);
7. Identification of current problems;
8. The consultation, laboratory and radiology reports filed in the medical record must contain the ordering provider's initials or other documentation indicating review;
9. Documentation of immunizations pursuant to 902 KAR 2:060;
10. Identification and history of nicotine, alcohol use or substance abuse;
11. 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;
12. Follow-up visits provided secondary to reports of emergency room care;
13. Hospital discharge summaries;

14. Advanced medical directives (for adults);
15. All written denials of service and the reason for the denial; and
16. Record legibility to at least a peer of the writer. Another reviewer evaluates a record judged illegible by an initial reviewer.

An enrollee’s medical record must include the following minimal detail for individual providers:

1. 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 abuse status;
2. Unresolved problems, referrals and results from diagnostic tests, including results and/or status of preventive screening services (i.e., EPSDT) are addressed from previous visits;
3. Plan of treatment, including:
 - Medication history, medications prescribed, including the strength, amount, directions for use and refills
 - Therapies and other prescribed regimen
 - Follow-up plans including consultation and referrals and directions, including time to return

An enrollee’s medical record must include, at a minimum, the following minimal detail for hospital and mental hospital visits:

1. Identification of the beneficiary
2. Physician name
3. Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 42 C.F.R. 456.172 (mental hospitals) or 42 C.F.R. 456.70 (hospitals). 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)
4. Reasons and plan for continued stay if applicable
5. Other supporting material appropriate to include

PCPs have the responsibility to discuss Advance Medical Directives with adult enrollees at the first medical appointment and chart that discussion in the medical record of the enrollee.

Access Standards

The quality improvement program includes evaluation of the availability, accessibility and acceptability of services rendered to enrollees by participating providers.

Please keep in mind the following access standards for differing levels of care. Participating providers are expected to have procedures in place to see enrollees within these time frames and to offer office hours to their Humana patients that are at least the equivalent of those offered to all other patients.

Primary care providers

Patients with:

Emergency needs

Urgent care

Routine care needs

Should be seen:

Immediately upon presentation; 24 hours a day, seven days a week

Not to exceed 48 hours from date of an enrollee’s request

Not to exceed 30 days from date of an enrollee’s request

NonPCP specialists

Patients with:

Emergency needs

Should be seen:

Immediately upon presentation

Urgent care

Not to exceed 48 hours

Routine care needs

Not to exceed 30 days from date of an enrollee’s request

Behavioral health providers

Patients with:

Emergency care

Should be seen:

Must be provided within six hours, crisis stabilization

Urgent care

Within 48 hours

Routine office visit

Shall not exceed 10 business days

Postdischarge from an acute psychiatric hospital Within seven days, but may not exceed 14 days*

*Providers must contact enrollees who have missed an appointment within 24 hours to reschedule.

Other referrals may not exceed 60 days.

General vision, lab and X-ray wait times must not exceed 30 days for regular appointments and 48 hours for urgent care.

Dental wait time must not exceed 30 days for regular appointments and 48 hours for urgent care.

An enrollee should be seen as expeditiously as the enrollee’s condition warrants based on severity of symptoms. If a provider is unable to see the enrollee within the appropriate time frame, then Humana facilitates an appointment with a participating provider or a nonparticipating provider when necessary.

The PCP provides or arranges coverage of services, consultation or approval for referrals 24 hours a day, seven days a week by Medicaid-enrolled providers who accept Medicaid reimbursement. This coverage should consist of an answering service, call forwarding, provider call coverage or other customary means approved by the agency. The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hours coverage must be accessible using the medical office’s daytime telephone number. The PCP arranges for coverage of primary care services during absences due to vacation, illness or other situations that require the PCP to be unable to provide services. A Medicaid-eligible PCP must provide coverage.

For the best interest of our enrollees and to promote their positive healthcare outcomes, Humana supports and encourages continuity of care and coordination of care between medical providers as well as between medical providers and behavioral health providers.

Preventive Guidelines 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 outcomes for clients.

The use of these guidelines allows Humana to measure the impact of the guidelines on outcomes of care. Humana monitors provider implementation of guidelines through the use of claim, pharmacy and utilization data.

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

- Provider manual updates
- Provider newsletters
- Provider website

Providers also can receive preventive health and clinical practice guidelines through the care management department or their provider relations representative.

Clinical Practice Registry

Accessible through our secure provider portal at **Availity.com**, the clinical practice registry helps PCPs improve patient health outcomes. The primary use of the registry is to help PCPs manage enrollee population. PCPs can quickly sort their Humana enrollees' into actionable groups to identify areas of focus. The clinical practice registry is a proactive approach to patient care and helps place emphasis on preventive care.

Key benefits of the registry include the following:

- After historical data is collected, the registry is color-coded and provides easy identification of enrollees in need of tests and/or screenings.
- The information can be downloaded as a PDF or to an Excel spreadsheet format (Please note: The Excel spreadsheet contains patient contact information).

Quality Assessment and Performance Improvement Program (QAPI)

Humana has a QAPI program that includes, but is not limited to, the following elements:

- Performance improvement projects
- Over- and underutilization measures
- Annual analysis of plan demographics, including clinical, geographical and cultural data points, to identify high-risk populations, areas of network need, enrollee education opportunities and performance improvement opportunities
- Assessment of access and availability of network providers, including after-hours availability of primary care providers
- Assessment of quality and appropriateness of care furnished to children with special healthcare needs
- Continuity and coordination of care
- HEDIS measurement
- CAHPS
- Annual measurement of effectiveness review of the QAPI

We welcome healthcare providers' input regarding our QAPI program. Feedback can be provided in writing to the following address:

Humana Quality Management Department
321 W. Main St., WFP 20
Louisville, KY 40202

External Quality Reviews

Through our contract with the Commonwealth of Kentucky, we are required to participate in periodic medical record reviews. The Commonwealth retains an external quality review organization (EQRO) to conduct medical record reviews for Humana enrollees.

Medical Record Review

You periodically may receive requests from Humana for medical record copies for a review. Your contract with Humana requires that you furnish enrollee medical records to us for this purpose. EQRO reviews are a permitted disclosure of an enrollee's personal health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA). As in the past, we plan to continue sharing the results of these studies and working in partnership to achieve the best healthcare possible for our enrollees.

Humana realizes that supplying medical records for review requires your staff's valuable time and we appreciate your cooperation with our requests and associated timelines. We offer the following suggestions to ensure complete and accurate documentation of enrollee services:

- Use legible handwriting for paper medical records
- Consider dictated notes, which can improve comprehension of medical records while reducing the chance of misinterpretation
- Include the patient's name on front and back of every page of the medical record
- Initial and date lab results in the medical record to indicate review by a physician
- Record all patient visit dates and sign all chart entries
- Consider using preprinted forms to document all aspects of comprehensive services, such as EPSDT exams

We appreciate your attention to detail in chart documentation.

Provider Performance and Profiling

As a function of utilization management oversight responsibilities, Humana monitors over- and underutilization of medical services. Provider profiling is performed periodically to measure utilization of common inpatient and outpatient services as preventive services, HEDIS clinical performance measures and pharmacy utilization. Summary reports for these measures are available to individual providers upon request, and routine periodic reporting is under development.

If a provider is found to be performing below minimum care standards for participation with Humana, this information is shared with the provider so he or she can make positive changes in practice patterns. We are committed to working with our providers to develop an action plan for improvement for those who do not meet standards. Further action may include onsite assessment, auditing medical care at specific intervals, disseminating comparative data or standards of care, meeting with physicians, reporting deficiencies to appropriate authorities or participation termination with Humana.

Fraud and Abuse Policy

Providers must incorporate a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse. Contracted physicians agree to educate his or her employees about the False Claims Act's prohibition on submitting false or fraudulent claims for payment, penalties for false claims and statements, whistleblower protections and each person's responsibility to prevent and detect fraud, waste and abuse.

Humana and KDMS should be notified immediately if a physician/provider or their office staff:

- Is aware of any physician/provider that may be billing inappropriately, e.g., falsifying diagnosis codes and/or procedure codes, or billing for services not rendered;
- Is aware of an enrollee intentionally permitting others to use his/her enrollee ID card to obtain services or supplies from the plan or any authorized plan provider;
- Is suspicious that someone is using another enrollee's ID card;
- Has evidence that an enrollee knowingly provided fraudulent information on his/her enrollment form that materially affects the enrollee's eligibility in the plan.

Providers may provide the above information via an anonymous phone call to Humana's Fraud Hotline at **1-800-614-4126**. All information will be kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Humana ensures no retaliation against callers because Humana has a zero-tolerance policy for retaliation or retribution against any person who reports suspected misconduct. Providers also may contact Humana at **1-800-4HUMANA (1-800-448-6262)** and Kentucky Cabinet for Health and Family Services at 1-800-372-2970.

In addition, providers may use the following contacts:

Telephonic:

- Special Investigations Unit (SIU) Direct Line: **1-800-558-4444 ext. 1500724** (8 a.m. to 5:30 p.m. Eastern time, Monday through Friday)
- Special Investigations Unit Hotline: **1-800-614-4126** (24/7 access)
- Ethics Help Line: **1-877-5-THE-KEY (1-877-584-3539)**

Email: SIUReferrals@humana.com or ethics@humana.com

Web: Ethicshelpline.com or Humana.com

Credentialing and Recredentialing

Humana conducts credentialing and recredentialing activities utilizing the guidelines established by the Kentucky Department of Medicaid Services (KDMS), the Centers for Medicare & Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Humana credentials and recredentials all licensed independent practitioners, including physicians, facilities and non-physicians, with whom it contracts and who fall within its scope of authority and action. Through credentialing, Humana verifies the qualifications and performance of physicians and other healthcare practitioners. A senior clinical staff person is responsible for oversight of the credentialing and recredentialing program.

All providers requiring credentialing should complete the credentialing process prior to the provider's contract effective date, except where required by state regulations. Additionally, a provider will only appear in the provider directory once credentialing is complete.

You may submit a completed Council for Affordable Quality Healthcare (CAQH) application via:

Humana
Attention: Credentialing
101 E. Main St.
Louisville, KY 40202
Fax: 1-502-508-0521
CredInquiries@Humana.com

Practitioner Credentialing and Recredentialing

All providers appearing in the provider directory are subject to credentialing and recredentialing. Practitioners within the scope of credentialing for Kentucky Medicaid include, but may not be limited to, the following:

- Medical and osteopathic doctors
- Oral surgeons
- Chiropractors
- Podiatrists
- Nurse practitioners
- Physician assistants
- Dentists
- Optometrists
- Audiologists
- Other licensed or certified practitioners, including physician extenders who act as a primary care provider or those that appear in the provider directory

Behavioral health practitioners:

- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctorial or master's level psychologists who are state certified or licensed
- Master's level clinical social workers who are state certified or licensed
- Master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed

- Other behavioral health specialists who are licensed, certified or registered by the state to practice independently, including licensed art therapists

CAQH Application

Humana is a participating organization with CAQH. Providers can confirm Humana have access to your credentialing application by completing the following steps:

1. Log onto the CAQH website at www.proview.caqh.org utilizing your account information
2. Select the Authorization Tab
3. Confirm Humana is listed as an authorized health plan; if not, please check the authorized box to add

Please include your CAQH provider ID number when submitting credentialing documents. It is essential that all documents are complete and current. Please include copies of the following documents:

- Current malpractice insurance face sheet
- A current Drug Enforcement Administration (DEA) certificate
 - All buprenorphine prescribers must have an “X” DEA number
- Explanation of all lapses in work history of more than six months or more
- Clinical Laboratory Improvement Amendment (CLIA) certificate, as applicable
- Copy of collaborative practice agreement between an advanced registered nurse practitioner and supervising practitioner.
- Education Council for Medical Graduates (ECFMG), if a foreign medical degree is held

Failure to submit a complete application may result in a delay in our ability to complete or begin the credentialing process.

Practitioner Credentialing and Recredentialing

The following elements are used to assess practitioners for credentialing and recredentialing:

- A. Signed and dated credentialing application, including supporting documents
- B. Active and unrestricted license in the practicing state issued by the appropriate licensing board
- C. Previous five-year work history
- D. Current DEA certificate and/or Kentucky narcotics registration, as applicable
- E. Education, training and experience are current and appropriate to the scope of practice requested, including:
 1. Successful completion of all training programs pertinent to one’s practice
 2. For M.D.s and D.O.s, successful completion of residency training pertinent to the requested practice type
 3. For dentists and other providers where special training is required or expected for services being requested, successful completion of training program
 4. Board certification, as applicable
- F. Current malpractice insurance coverage at the minimum amount in accordance with Kentucky laws
- G. In good standing with:
 1. Medicaid agencies
 2. Medicare program
 3. Health and Human Services — Office of Inspector General (HHS-OIG)
 4. General Services Administration (GSA, formerly EPLS)

- H. Active and valid Kentucky Medicaid ID number
- I. Active hospital privileges, as applicable
- J. National Provider Identifier (NPI), as verifiable via the National Plan and Provider Enumerator System (NPES)
- K. Quality of care and practice history as judged by:
 - 1. Medical malpractice history
 - 2. Hospital medical staff performance
 - 3. Licensure or specialty board actions or other disciplinary actions, medical or civil
 - 4. Lack of enrollee grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall enrollee satisfaction
 - 5. Other quality of care measurements/activities

Organizational Credentialing and Recredentialing

The organizational providers to be assessed at credentialed and recredentialed include, but are not limited to:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free standing ambulatory surgery centers
- Hospice providers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting
- Dialysis centers
- Physical, occupational therapy and speech language pathology (PT/OT/SLP) facilities
- Rehabilitation hospitals (including outpatient locations)
- Diabetes education
- Portable X-ray suppliers
- Rural health clinics and federally qualified health centers
- Free standing birth centers

The following elements are assessed for organizational providers:

- 1. Organization is in good standing with:
 - a. Medicaid agencies
 - b. Medicare program
 - c. Health and Human Services-Office of Inspector General (HHS-OIG)
 - d. General Services Administration (GSA, formerly EPLS)
- 2. Organization has been reviewed and approved by an accrediting body
- 3. Copy of facility's state license, as applicable
- 4. CLIA certificates are current, as applicable
- 5. Completion of a signed and dated application
- 6. Organization will be informed of the credentialing committee's decision within 60 business days of the committee meeting.
- 7. Organizational provider are reassessed at least every three years

Provider Recredentialing

Network providers, including practitioners and organizational providers, are recredentialed at least every three years. As part of the recredentialing process, Humana considers information regarding performance to include complaints and safety and quality issues collected through the quality improvement program. Additionally, information regarding adverse actions is collected from the National Practitioner Data Bank (NPDB), Medicare and Medicaid Sanctions, CMS Preclusion list, the HHS/OIG and GSA (formerly EPLS), and limitations on licensure.

Practitioner Rights

- Practitioners have the right to review, upon request, information submitted to support his or her credentialing application to the Humana Credentialing department. Humana keeps all submitted information secured and confidential. Access to electronic credentialing information is password protected and limited to staff that require access for business purposes.
- Practitioners have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the credentialing department prior to presentation to the credentialing committee. If information obtained during the credentialing or recredentialing process varies substantially from the application, the practitioner is notified and given the opportunity to correct information prior to presentation to the credentialing committee.
- Practitioners have the right to be informed of their credentialing or recredentialing application status on written request to the credentialing department.

Provider Responsibilities

Network providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. Humana initiates immediate action in the event that participation criteria are no longer met. Network providers are required to inform Humana of changes in status, including but not limited to, being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure or board certification, an event reportable to the NPDB, federal, state or local sanctions, or complaints.

Delegation of Credentialing/Recredentialing

Humana only enters into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated is accredited by NCQA for these functions or utilizes a NCQA-accredited credential verification organization (CVO) and successfully passes a predelegation audit demonstrating compliance with NCQA federal and state requirements. A predelegation audit must be completed prior to entering into a delegated agreement. All pre-assessment evaluations are performed using the most current NCQA and regulatory requirements. The following are included (at a minimum) in the review:

- Credentialing and recredentialing policies and procedures
- Credentialing and recredentialing committee meeting minutes from the previous year
- Credentialing and recredentialing file review

Delegates must be in good standing with Medicaid and CMS. Monthly reporting is required from the delegated entity, which is defined in an agreement between both parties.

Reconsideration of Credentialing/Recredentialing Decisions

Humana's credentials committee may deny a provider's request for participation based on credentialing criteria. The credentials committee must notify a provider of a denial that is based on credentialing criteria and provide the opportunity to request reconsideration of the decision within 30 days of the notification. Reconsideration

opportunities are available to a provider if he or she is affected by an adverse determination. To submit a reconsideration request, the following steps apply:

Mail a reconsideration request to the senior medical director. A reconsideration request must be in writing and include any additional supporting documentation. Send a reconsideration request to:

Humana
Attn: Catalin Jurnalov, M.D.
Regional Medical Director
101 E. Main St.
Louisville, KY 40202

On reconsideration, the credentials committee may affirm, modify or reverse its initial decision. Humana notifies the applicant in writing within 60 days of the credentials committee's reconsideration decision within 60 days. Reconsideration denials are final unless the decision is based on quality criteria and providers have the right to request a state fair hearing. Practitioners who were denied are eligible for reapply for network participation once they meet the minimum health plan's credentialing criteria.

Applying providers do not have appeal rights. However, they may submit additional documents to the address above for reconsideration by the credentialing committee.

Appendix I – Forms

<Appendix II –Kentucky HEALTH>

<Insert KY-KHHU0-0170>



KHHU00170 KY
HEALTH Provider Ma

Kentucky HEALTH Eligibility

Kentucky HEALTH is the Commonwealth’s new health and well-being program for certain low-income adults and their families. The program derives its name from its mission; the word HEALTH stands for Helping to Engage and Achieve Long Term Health. This appendix addresses information specific to Kentucky HEALTH.

Kentucky HEALTH Eligibility

Kentucky HEALTH is the Commonwealth's new plan. The word HEALTH stands for Helping to Engage and Achieve Long Term Health.

The goal of this new plan is to help Medicaid enrollees become more active in their own health and well-being. It also aims to encourage healthier lifestyles and community engagement. Kentucky HEALTH is designed for working-age adults and their families. This applies all non-disabled Medicaid enrollees, including:

- Medicaid expansion adults
- Low-income parents and caregivers
- Former foster youth up to age 26
- Pregnant women
- Nondisabled children

Kentucky HEALTH is NOT for people who are on Medicare (older than 65) or those who are on traditional Medicaid due to age or disability, such as:

- Aged, blind or disabled individuals
- Supplemental Security Income (SSI) recipients
- Individuals in long-term care
- Breast and Cervical Cancer Treatment Program (BCCTP) participants
- Adoption subsidy Medicaid individuals
- Department of Juvenile Justice Medicaid individuals
- Time-limited emergency Medicaid individuals, such as undocumented immigrants

The Kentucky HEALTH plan requires enrollees to participate in the following activities:

- **Cost sharing:** Enrollees pay premiums or make copayments toward services. The copayment plan is a penalty for failure to make premium payments. Enrollees on the copayment plan do not have access to a My Rewards Account.
- **Premium:** The amount of an eligible enrollee's premium is determined according to household income. If enrollees make their premium payments, they are eligible for a My Rewards Account.
- **My Rewards account:** Allows enrollees access to **enhanced health benefits that otherwise are not covered**, including dental and vision. Enrollees can add "dollars" to their accounts by completing health and well-being activities or participating in extra community engagement activities beyond the required hours. The My Rewards Account is subject to balance deductions, for example, for inappropriate use of the emergency room.
- **Deductible account:** The deductible account acts like a health savings account. KDMS pays \$1,000 into the account at the beginning of the year. During the year, the account pays for the first \$1,000 of nonpreventive medical expenses. Once the account is depleted, all medical services will continue to be covered by Humana. At the end of the calendar year, up to 50 percent of the remaining deductible balance may be rolled over into the enrollee's My Rewards account.
- **Community engagement:** Enrollees must work or participate in qualifying activities to remain eligible for Kentucky HEALTH benefits.

Verify Eligibility

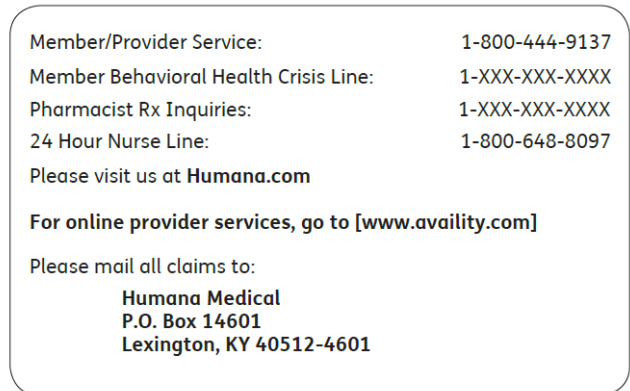
Enrollees are asked to present an ID card each time services are accessed. Before providing all services EXCEPT emergency services, providers are expected to verify enrollee eligibility. Please use HealthNet to verify enrollee eligibility on the date of service for Kentucky HEALTH enrollees.

If you are not familiar with the person seeking care and cannot verify the person as an enrollee of our health plan, please ask to see photo identification.

Kentucky HEALTH Card Front:



Back:



Kentucky Health Card Front:

- **Enrollee Name**
- **Enrollee ID number:** Use this number on claims.
- **Medicaid ID number:** Please do **not** use this number to bill Humana.
- **Primary Care Provider/Clinic Name:** Each enrollee chooses a participating provider to be his or her primary care provider (PCP). If a choice is not made, a PCP is assigned.
- **Enrollee Services:** Phone number and TTY for the hearing impaired.
- **24-hour nurse line:** Phone number to reach a registered nurse 24 hours a day, seven days a week, 365 days a year.

Kentucky Health Card Back:

- **Behavioral health hotline:** Enrollees can call this hotline 24 hours a day, seven days a week, 365 days a year for mental health or addiction services.
- **Website:** Our website contains plan information and access to special functionality, such as eligibility verification, claim and prior-authorization submission, coordination of benefits (COB) check and more.
- **Healthcare provider services:** Use this toll-free phone number if you have questions or wish to verify eligibility over the phone.
- **Mail medical claims to:**
Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601
- **Pharmacy:** Call Provider Services if you have questions about pharmacy benefits and services.

Payment Responsibility

HealthNet

HealthNet is the Commonwealth’s web portal for access to enrollee eligibility, managed care organization (MCO) enrollment and cost-share requirement validation information. It contains many of the tools necessary for enrollee administrative tasks. To access HealthNet, visit www.kymmis.com/kymmis/index.aspx. Registration is required.

KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Kentucky Medicaid Web Site

For assistance, email us at KY_EDU_HelpDesk@hpe.com or call (800) 205-4696 during normal business hours 7:00 am - 6:00 pm Monday - Friday EST.

Sign in to the KyHealth Choices

- Manage your contact information
- Change your password
- Providers: Manage your agent's access

If you are a billing agent or you wish to complete a provider application you may register [here](#).

Sign in to KyHealth Choices [Help](#)

Username

Password

KyHealth Choices
[Reset your password](#)

[Contact Us](#)

[Privacy](#) | [Disclaimer](#) | [Individuals with Disabilities](#)

HealthNet displays the enrollee's date of eligibility, suspension, termination, cost-share requirement, their MCO, the Medicaid plan and My Rewards reservations.

You can use HealthNet to determine if an enrollee is on a copayment plan to collect the appropriate copayment amount and if they met their cost-share requirement for the quarter. You can determine if an enrollee has dental and vision coverage, and if so, whether the coverage is through the enrollee's My Rewards Account or through the MCO.

When applicable, it also displays an enrollee's suspension, as well as the reason.

Suspension and Penalty Codes

If an enrollee has one of the following penalty codes, his or her benefits are suspended or changed to a copay plan:

- CS – Community Engagement Suspension
- PS – Premium Nonpayment Suspension

If an enrollee has one of the following penalty codes, he or she has six months to address the issue. If the issue remains unresolved after six months, the enrollee loses all Medicaid eligibility:

- QP – Recertification Penalty
- RP – Report a Change Penalty
- VP – Voluntary Withdrawal Penalty

If an enrollee has one of the following penalty codes, he or she has six months to address the issue. If the issue remains unresolved after six months, the enrollee then moves into a suspension status:

- CP – Community Engagement Penalty
- PP – Premium Non-payment Penalty

All services are considered non-covered while an enrollee is in suspended status. Federal regulations prohibit Medicaid providers from inappropriately billing Medicaid enrollees for covered Medicaid services, but there is no federal language prohibiting a provider from billing for a noncovered service. Therefore, providers may bill suspended Kentucky HEALTH enrollees for services rendered during the time of the enrollee's suspension.

Copayment

HealthNet indicates in the Eligibility panel if an enrollee owes a copayment for services. If Y displays in the Copay Plan field, the enrollee is subject to copayments.

Eligibility					
Eligibility 5 Year History					
Eligibility Group	Program Code	Program Status	Pov Ind	From Date of Service	To Date of Service
KY Managed Care Organization without Co-Pay	XC - Child	P1 - Child at least 6 and under 19, Attending School if 18	N	01/01/2017	01/01/2018
Copay Plan		From Date	To Date		
Y		06/01/2017	12/31/2017		
Copay Indicator		From Date	To Date		
Y		10/04/2016	10/04/2017		

Note: POV_IND - An 'N' in this field indicates that the member is at or below 100% of the federal poverty level. If the indicator is 'N' you may not refuse to provide services for no payment of co pays. If the indicator is 'Y' you may refuse to provide services for non-payment of co pays if this is the current business practice for all patients.

Regarding Copay Plan: A value of 'Y' indicates the member is subjected to Co-Payments and is not subjected to Premium payments. A value of "N" indicates the member is not subjected to Co-Payments but may be subjected to Premium Payments.

Enrollment in a copayment plan occurs when a Kentucky HEALTH enrollee fails to make premium payments or transitions from a plan that does not include premiums (e.g., aging out).

Enrollees in the copayment plan are eligible for all covered benefits available in their benefit package, but are required to pay a copayment for each service received.

An enrollee could be enrolled in a copayment plan (Y displays in the Copay Plan field) but not be responsible for making the copayment (N displays in the Copay Indicator field). This occurs when family copayments and premiums reach 5% of the family income. Kentucky HEALTH limits cost sharing to 5% of the family income on a quarterly basis. Enrollees making premium payments are not subject to copayments for services.

Enrollees eligible for Medicaid Early, Periodic Screening and Diagnostic Testing (EPSDT) benefits do not have premiums, copayments or My Rewards accounts.

Collect Copayment Amounts

Providers should bill and collect copayments from Kentucky HEALTH enrollees, as copayment amounts are subtracted from claim payments for services.

HealthNet displays copayment requirements for services rendered for enrollees. It also details if the enrollee has met the 5% cost-share limit for the quarter.

Benefit	Copayment amount
Acute inpatient hospital admission	\$50
Outpatient hospital or ambulatory surgical center visit	\$4
Generic prescription drug	\$1
Preferred branded drug	\$4
Preferred branded drug that does not have a generic equivalent	\$4
Emergency room for nonemergent visit	\$8
Durable medical equipment	\$4

Podiatry office visit	\$3
Chiropractic office visit	\$3
Dental office visit	\$3
Optometry office visit	\$3
General ophthalmological office visit	\$3
Physician office visit	\$3
Office visit; care by a physician assistant, advanced practice registered nurse, certified pediatric and family nurse practitioner or nurse midwife	\$3
Office visit; behavioral health care	\$3
Office visit; rural health clinic	\$3
Office visit; federally qualified health center (FQHC) or a FQHC look-alike	\$3
Office visit; primary care center	\$3
Physical therapy office visit	\$3
Occupational therapy office visit	\$3
Speech-language pathology services office visit	\$3
Laboratory, diagnostic or radiological service	\$3

Inability to Pay Copayment

Providers are prohibited from denying care to any enrollee with a household income less than 100 percent of the federal poverty level (FPL) because of an inability to pay the copayment amount. However, if the provider has a policy posted in the office that applies to all patients, he or she can deny care to enrollees with household incomes above 100 percent of the FPL.

The Pov Ind field in the Eligibility panel in HealthNet indicates if an enrollee is at or below 100 percent of the FPL. If the indicator is N, you may not refuse to provide services for nonpayment of copays.

Eligibility					
Eligibility 5 Year History					
Eligibility Group	Program Code	Program Status	Pov Ind	From Date of Service	To Date of Service
KY Managed Care Organization without Co-Pay	XC - Child	P1 - Child at least 6 and under 19, Attending School if 18	N	01/01/2017	01/01/2018
Copay Plan		From Date	To Date		
Y		06/01/2017	12/31/2017		
Copay Indicator		From Date	To Date		
Y		10/04/2016	10/04/2017		

Note: POV_IND - An 'N' in this field indicates that the member is at or below 100% of the federal poverty level. If the indicator is 'N' you may not refuse to provide services for no payment of co pays. If the indicator is 'Y' you may refuse to provide services for non-payment of co pays if this is the current business practice for all patients.
Regarding Copay Plan: A value of 'Y' indicates the member is subjected to Co-Payments and is not subjected to Premium payments. A value of 'N' indicates the member is not subjected to Co-Payments but may be subjected to Premium Payments.

Third-party Contributions to Premiums

Providers or provider-affiliated entities who make third-party contributions towards a Kentucky HEALTH enrollee's premium payment on behalf of the enrollee:

- May not distinguish between enrollees based upon whether enrollees receive services from the contributing provider(s) or class of provider(s)
- May not include the cost of the Kentucky HEALTH premium contribution in the cost of care for purposes of Medicare and Medicaid cost reporting or as part of a Medicaid shortfall or uncompensated care

Non-emergency Use of the Emergency Room (ER)

Enrollees in the Kentucky HEALTH program are penalized for inappropriate ER use.

In addition, some enrollees are required to make copayments for ER visits. As noted in the preceding graph, enrollees are responsible for an \$8 copayment for nonemergency use of the ER. Humana will deduct \$8 from the provider's claim reimbursement for services rendered during an improper use of the ER. Hospitals must make a good-faith effort to collect the \$8 copayment from the enrollee.

Enrollees who have a My Rewards account and are enrolled in a premium plan receive a deduction of their account balance for improper ER use. Nonemergency use of the ER results in a deduction from the My Rewards account, and the amount escalates for each inappropriate visit. The number of improper uses per calendar year is tracked, and every additional improper use of ER services increases the value of the penalty.

Number of inappropriate ER visits	Penalty deduction applied
One	\$20
Two	\$50
Three or more	\$75

However, enrollees can call our 24-hour nurse advice line before they go to the ER. If the nurse advice line recommends that the enrollee go to the emergency room, no deduction from the My Rewards Account will be made, even if the visit was not an emergency.

Providers are required to communicate the following with the enrollee **before** providing nonemergency treatment in the emergency room:

- Inform enrollees in the copayment plan of the amount of their cost-sharing obligation for nonemergency services provided in the ER.
- Inform enrollees with a My Rewards account that the nonemergency visit results in a deduction from the My Rewards account and that the amount of the deduction increases for each inappropriate ER visit.
- Provide the enrollee with the name and location of an available and accessible alternative nonemergency services provider.
- Determine that the alternative nonemergency services provider can provide services to the enrollee in a timely manner with the imposition of a lesser cost-sharing amount.
- Provide a referral to coordinate scheduling for treatment by the alternative provider.

Medically Frail

Enrollees designated as medically frail are not required to participate in cost sharing, My Rewards or community engagement to maintain benefit coverage through the Kentucky HEALTH plan. However, medically frail enrollees have the option to pay a monthly premium, and if they do, they have access to a My Rewards Account. They also have the option to participate in community engagement activities through the Partnering to Advance Training and Health (PATH) program, which provides job resources free of charge.

Enrollees may be considered medically frail for many different reasons. Some of those reasons include:

- Disabling mental health diagnosis
- Chronic substance-use disorder
- Serious and complex medical condition
- A physical, intellectual or developmental disorder that significantly impairs their ability to perform activities of daily living
- Diagnosed with HIV/AIDS as identified by the Ryan White HIV/AIDS Program

- Eligible for Social Security Disability Insurance (SSDI)
- Chronic homelessness
- Domestic violence status

Enrollees must be screened to obtain their medically frail status. Humana staff reaches out to enrollees identified as potentially medically frail and assists them with setting up an appointment with their primary care, specialty or behavioral health provider.

Redetermination

An enrollee determined as medically frail holds that eligibility status for up to 12 months, effective from the first of the month the determination was made. An enrollee must be assessed annually to verify medically frail status before the 12-month eligibility status period is exhausted.

For enrollees who require status redeterminations, Humana conducts a medically frail assessment of the enrollee, which must include completion of the Medically Frail Provider Attestation. On completion of the assessment, Humana notifies KDMS if the enrollee meets the requirements for a medically frail determination. On final determination, KDMS updates HealthNet to reflect the enrollee's medically frail status.

Self-attestation

Enrollees indicate that they are in poor health by completing a Health Screening Assessment through the Commonwealth's self-service portal or with the assistance of a Department for Community Based Services (DCBS) case worker in the worker portal. If an enrollee self-attests to homelessness or difficulties with activities of daily living, they receive a medically frail determination for a period of up to six months from the month the enrollee self-attested.

Enrollees can report domestic violence to DCBS. Reporting enrollees are then classified as medically frail for 12 months. Enrollees can contact DCBS by calling 1-855-306-8595 or visiting a local DCBS office.

My Rewards

Dental and vision providers use the My Rewards reservation page in HealthNet to reserve funds for Kentucky HEALTH enrollees who have dental and vision coverage through their My Rewards accounts.

The following enrollees DO NOT use their My Rewards Accounts to access dental and/or vision benefits:

- Enrollees eligible for vision and dental services through the Medicaid State Plan (i.e., traditional Medicaid enrollees, low-income parents and caretakers, medically frail and former foster care youth, pregnant women and children)
- Children (birth through age 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

While providers are not required to reserve My Rewards funds to receive payment for a claim, the claim is denied if sufficient funds are not available in the enrollee's My Rewards account.

Reservations

A reservation only can be made up to 60 days prior to the date of service. The payable amount is deducted from the My Rewards account when a claim is submitted. The reservation expires 30 days after the scheduled date of service.

My Rewards dental services are limited to dental and professional claims submitted by the following billing providers or billing/rendering provider combinations:

- 60 – General dentist
- 61 – General dentist clinic
- 64 – Individual physician/oral surgeon only
- 65 – Physician clinic: Covered only if the rendering provider is an oral surgeon (provider type 64)
- 31 – Primary care center: Covered only if the rendering provider type is a general dentist (provider type 60) or an oral surgeon (provider type 64)
- 35 – Rural health center: Covered only if the rendering provider type is a general dentist (provider type 60) or an oral surgeon (provider type 64)

My Rewards vision services are limited to professional claims submitted by the following billing providers or billing/rendering provider combinations:

- 77 – Optometrist
- 64 – Individual physician/ophthalmologist only
- 65 – Physician clinic: Covered only if the rendering provider is an ophthalmologist (provider type 64)
- 31 – Primary care center: Covered only if the rendering provider type is an optometrist (provider type 77) or an ophthalmologist (provider type 64)
- 35 – Rural health center: Covered only if the rendering provider type is an optometrist (provider type 77) or an ophthalmologist (provider type 64)
- 20 – Preventive services

To reserve My Reward funds for an eligible enrollee, enter the enrollee's information, procedure code, date of service and rendering provider ID (if applicable) and click Submit.

The reservation amount is systemically populated with the payable amount from the Medicaid fee schedule. A confirmation number displays if the submission is successful.

If the enrollee's My Rewards balance is insufficient to cover the requested service, the provider is unable to complete the reservation.

Enrollees who do not have an adequate My Rewards balance to cover enhanced health benefits may pay out-of-pocket. If the enrollee wants to receive My Rewards funds for the services, the enrollee may request from the provider an itemized list of services to include the appropriate service and diagnosis codes.

Changes

If an enrollee reschedules services, the provider can edit the date of service on a My Rewards Account reservation. The date of service cannot exceed the expiration date, and the expiration date remains the same as the original reservation's expiration date.

A provider can add an additional procedure code to a reservation only on the same date of service as the original reservation or on the next business day.

A provider can cancel a reservation to allow funds to be released back into the enrollee's account for future use.

Inquiries

Use the My Rewards Inquiry page in HealthNet to view a list of currently reserved funds for all of a provider's enrollees. You can enter an enrollee ID to limit your results. An enrollee's current My Rewards account status is

displayed to indicate if the enrollee has been active, suspended, inactive or closed since the reservation was made.

All reservations set to expire in five days are highlighted in yellow to alert you that no claim has been submitted and the hold is about to expire.

Claims

My Rewards claim submissions are limited to one year from the date of service, regardless of whether the provider initially submits the claim within the year but is denied. If a provider's My Rewards claim is denied, the claim must be resubmitted within one year of the date of service.

Dental and vision claims paid to Medicaid-eligible providers through My Rewards cannot be adjusted by the provider. If the provider needs to change data on a My Rewards-paid claim for any reason, he or she needs to void the claim, request a new reservation of funds and resubmit the claim.

My Rewards claims must be submitted on paper or via HealthNet as fee-for-service claims are submitted today.