Humana Medicaid Provider Orientation and Training

Information for Medicaid healthcare providers and administrators

2020 Kentucky

Humana.®

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Training topics

	Topic	General guidance	Page
1.	**About Humana**	• Types of offerings • Company size, revenue and membership	5
2.	**Humana's Kentucky Medicaid plan**	• The purpose and eligibility of the program	7
3.	**Enrollee eligibility and copayments**	• Humana-issued identification cards • Verifying eligibility • Copayments	9
4.	**Covered services**	• Covered services • Enrollee services	19
5.	**Humana's value-added services**	• Description of value-added services	25
6.	**Contracting and credentialing**	• Requirements • Contact information	28
7.	**Access to care requirements**	• Requirements to ensure access to enrollees	33
8.	**Referrals and prior authorizations**	• Referrals • Prior authorization requirements and process • Retrospective reviews	38

Training topics (cont'd)

	Topic	General Guidance	Page
9.	**Claims processing and claims resolution process**	• Electronic and paper claim submissions • Encounter submissions • Timeliness requirements • Online resource for claim status and edit questions • Claim escalation or dispute process and contacts • Electronic claims payment option • Balance billing	47
10.	**Provider grievance and appeals**	• Grievances • Appeals and expedited appeals • Submitting to KDMS	57
11.	**Continuity of Care (COC)**	• Enrollees with special healthcare needs • Transitioning during pregnancy	63
12.	**Care management programs**	• Care management overview and functions • Chronic condition management • Enrollee incentive programs • Maternal and transition programs	67
13.	**Utilization management**	• Health services and utilization management • Discharge support	73
14.	**Pharmacy**	• Benefit summary • Drug prior authorization and notification • Prescriber quick reference guide	77

Training topics (cont'd)

	Topic	General Guidance	Page
15.	**Quality**	• Quality improvement requirements • External quality review organization	81
16.	**Electronic Health Records (EHR)**	• Advantages of EHR • EHR Incentive Program	85
17.	**Marketing guidelines**	• General guidelines	91
18.	**Additional training requirements and provider responsibilities**	• List of other trainings, where to find them and how to assure completion is documented • Advance directives	93
19.	**Fraud, waste and abuse**	• Requirement to report, reporting options and protections related to reports of suspected false claims	96
20.	**Web resources**	• Helpful web addresses	100
21.	**Helpful numbers**	• Toll-free; hours listed for non-24/7 phone numbers	103

1.
About Humana

About Humana

- Insurance products
- Health and wellness services
- $39 billion in annual revenues
- 50,000 employees
- Plans for employer groups, individuals and government agencies
- Commercial, Medicare and Medicaid (in select markets)
- Plans include health, dental, vision and behavioral health
- 14.3 million medical members
- 7 million specialty members

2.
Humana's Kentucky Medicaid Plan

Humana's Kentucky Medicaid Managed Care Plan

- Humana was awarded a Managed Care Organization (MCO) contract to administer a Kentucky Medicaid plan, effective Jan. 1, 2013.

  - Humana and CareSource jointly managed the plan through Dec. 31, 2019.

  - Effective Jan. 1, 2020, Humana is the sole plan administrator.

- Humana is committed to the Kentucky Department of Medicaid Services' (KDMS) Triple Aim approach to achieve:

  - Better health

  - Better care

  - Lower costs

- We focus on prevention and partnering with local providers to offer integrated care that our enrollees need to be healthy.

- Humana's Kentucky Medicaid Plan is available statewide to eligible enrollees.

3.
Enrollee eligibility and copayments

Enrollee eligibility

- Medicaid eligibility is determined by the Department for Community Based Services (DCBS) in the county where the consumer resides.
- Eligibility begins on the first day of each calendar month, including the initial application month, with two exceptions:
  - Newborns, born to an eligible mother, are eligible at birth.

  - The delivery hospital is required to enter the birth record in the Kentucky Certificate of Live Birth, Hearing, Immunization and Lab Data (KY CHILD) birth record system. This information is used to auto-enroll eligible newborns within 24 hours of birth.

  - When the mother is enrolled in the Humana Health Plan, newborn coverage begins on the date of birth. The newborn appears on the primary care physician's (PCP's) enrollee eligibility list after Humana adds it to its system.

  - Consumers who meet the definition of unemployed in accordance with federal regulation 45 CFR 233.100 are eligible on the date they are deemed unemployed.

Enrollee eligibility – identification cards

- Humana will reissue ID cards Jan. 1, 2020. The enrollee's group ID and enrollee ID will change at this time.

Humana.

Humana Health Plan

ENROLLEE NAME
Enrollee ID: HXXXXXXXX

Medicaid ID#: XXXXXXXX   Group #: XXXXXXX
Date of Birth: XX/XX/XX   RxBIN: 610649
Effective Date: XX/XX/XX   RxPCN: 03191501

PCP Name: XXXXXXXXX
PCP Phone: (XXX) XXX-XXXX

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

- Enrollees also will receive a new Kentucky Medicaid ID card. Enrollees' Medicaid ID numbers will not change effective Jan. 1, 2020.

Enrollee eligibility (cont'd)

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

Kentucky Medicaid copayments

What is a copay?

A copay is a fee charged for some healthcare services. When a service that requires a copay is delivered by a provider, the provider is paid at the time of service. Enrollees can ask if there is a copay when an appointment is scheduled

Who is exempt from copays?

Enrollees who are exempt are not required to pay copays. Exemptions may apply, and are not limited, to:

- Foster children
- Children enrolled in Medicaid
- Pregnant women (includes 60-day period after pregnancy ends)
- Kentucky Medicaid enrollees who reached their cost-sharing limit for the quarter
- Individuals receiving hospice care

Are other services exempt from copays?

Exemptions may apply, and are not limited, to:

- Emergency services
- Some family planning services
- Preventive services

Kentucky Medicaid copayments (cont'd)

What do you need to know about Medicaid copays?

Many Medicaid enrollees already pay copays. As of Jan. 1, 2019, all enrollees who are not otherwise exempt pay copays for some services.

- **Preventive services DO NOT HAVE COPAYS.** Preventive services include screenings, check-ups and patient counseling to prevent illnesses, disease or other health problems.
- This copay policy began Jan. 1, 2019, regardless of the program's status.

Copay listing

Benefit	Enrollee pays
Preventive health services	$0
Office visits	$3
Doctor services	$3
Branded drug	$4
Generic drug	$1
Branded drug preferred over generic	$1
Chiropractic visits	$3
Pregnancy care	$0
Family planning services	$0

Copay listing (cont'd)

Benefit	Enrollee pays
Foot care	$3
Dental care	$3
Vision care	$3
General ophthalmologist services	$3
Rural health clinic, primary care center or federally qualified health center visits	$3
Physical, speech and occupational therapy	$3
Outpatient hospital services	$4
Emergency room services	$0
Emergency room visits for a nonemergency	$8

Copy listing (cont'd)

Benefit	Enrollee pays
Inpatient hospital visits	$50
Durable medical equipment	$4
Ambulatory surgery center visits	$4
Lab, diagnostic or X-ray services	$3

Inability to pay copayment

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

- The Pov Ind field in the Eligibility panel in HealthNet indicates if a member 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.

- Please refer to HealthNet for further details at kymmis.com/kymmis/index.aspx.

4.
Covered services

Covered services

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

Alternative birthing center services	Hearing services, including hearing aids for enrollees younger than 21
Ambulatory surgical center services	Home health services
Behavioral health services – mental health and substance abuse disorders	Hospice services (non-institutional only)
Chiropractic services	Independent laboratory services
Community mental health center services	Inpatient hospital services
Dental services, including oral surgery, orthodontics and prosthodontics	Inpatient mental health services
Durable medical equipment, including prosthetic and orthotic devices and disposable medical Supplies	Meals and lodging for appropriate escort of enrollees
Early and Periodic Screening, Diagnosis & Treatment (EPSDT) screening and special services	Medical detoxification, meaning management of symptoms during the acute withdrawal phrase from a substance to which the individual has been addicted
End-state renal dialysis services	Medical services including, but not limited to, those provided by physicians, advanced-practice registered nurses, physician assistants, FQHCs, primary care centers and rural health clinics
Family planning services in accordance with federal and state law and judicial opinion	Organ transplant services not considered investigational by FDA

Covered services (cont'd)

Other laboratory and X-ray services	Specialized children's services clinics
Outpatient hospital services	Targeted case management
Outpatient mental health services	Therapeutic evaluation and treatment, including physical therapy, speech therapy, occupational therapy
Pharmacy and limited over-the-counter drugs including mental/behavioral health drugs	Transportation to covered services, including emergency and ambulance stretcher services
Podiatry services	Urgent and emergency care services
Preventive health services, including those currently provided in public health departments, FQHCs/primary care centers and rural health clinics	Vision care, including vision examinations, services of opticians, optometrists and ophthalmologists, including eyeglasses for enrollees younger than 21
Psychiatric residential treatment facilities (Level I and Level II)	Specialized care management services for enrollees with complex chronic illnesses (includes adult and child targeted case management)

PCPs are required to have screening and evaluation procedures in place for the detection and treatment of, or referral for, known or suspected behavioral health problems and disorders.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

- Enrollees eligible for Medicaid EPSDT benefits do not have copayments.
- Children (birth through 18) and adults (19 through the end of the 21st birthday month) eligible for Medicaid's EPSDT program continue to receive vision and dental coverage through EPSDT coverage.

Benefits and services

Humana offers several benefits and services for Medicaid enrollees, including:

- Case management and behavioral health services for our enrollees with chronic health conditions
- Local pharmacy support to help enrollees learn about their medication needs and drug safety
- Behavioral health services that include a dedicated hotline and crisis intervention
- Dental services based on enrollee coverage
- Prenatal, postnatal and well-baby incentive program for pregnant women and newborns, to encourage healthy behaviors and preventive care
- A toll-free phone number for enrollees to speak with a registered nurse about their health concerns 24 hours a day, seven days a week at 1-800-648-8097

Enrollee services

Humana enrollees enjoy a range of support and care services, including:

- Referrals to community resources and/or case management
- Support and education for chronic conditions such as asthma and diabetes
- Assistance with finding a primary care practitioner
- Access to grievances and appeals processes
- Support for claims issue resolution
- Help with benefit inquiries
- Access to pharmacy benefits
- Help with prior authorization requests
- Interpretation services support

5.
Humana's value-added services

Value-added services (VAS)

- VAS are benefits offered by Humana that are not otherwise covered or that exceed limits outlined in the Kentucky State Plan and the Kentucky Medicaid Fee Schedules.
- Humana Medicaid enrollees have specific enhanced benefits. Please see the enrollee handbook for benefit descriptions and details.

VAS offered by Humana

- Child obesity program
- Dental services – Additional cleaning for enrollees 21 and older
- Moms 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
- General equivalency diploma (GED) testing
- Criminal expungement services
- Cell phone services
- Immunizations – Allowance of an additional vaccine for enrollees 21 and older (rabies)

6.
Contracting and credentialing

Contracting process

To enroll as a practitioner in Medicaid or to contract with Humana for medical or behavioral health services, please call 1-800-457-5683 and select option 4, or send an email to providerdevelopmentkywv@humana.com.

To contract with Humana for behavioral health services, please send an email to kybhmedicaid@humana.com.

Humana works with the following networks to provide dental, vision, pharmacy and chiropractic services. To request participation, please contact the appropriate network below:

Coverage type	Network	Contact
Dental	Avesis	1-888-211-0599
Vision	Avesis	1-844-511-5760
Pharmacy	Humana	pharmacycontracting@humana.com
Chiropractic	Tivity	WHNRecruitment@trivityhealth.com

Contracting process

Please include the following in your email:

- Physician/practice/facility name
- Service address with phone, fax and email information
- Mailing address, if different than service address
- Tax Identification Number (TIN)
- Specialty
- Medicaid provider number (with corresponding registered provider-specialty code and provider-type code)
- National Provider Identifier (NPI)
- Type of contract

  (e.g., individual, group, facility)

- Council for Affordable Quality Healthcare (CAQH) number

> After receipt and review of your request, a provider-contracting representative will contact you.

Provider and enrollee rights and responsibilities

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

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

Credentialing

- Healthcare providers must be credentialed prior to network participation in order to treat Humana enrollees.
- Recredentialing occurs at least every three years. Some circumstances require shorter recredentialing cycles.
- Humana participates with the Council for Affordable Quality Healthcare (CAQH®) for applicable provider types.
- Healthcare providers must be screened by and enrolled with KDMS to be considered for participation.
- In addition to being in good standing with Medicare, federal, state and local agencies, healthcare providers must not appear on the Terminated and Excluded Provider List published by KDMS.

Further details regarding Humana's credentialing/recredentialing requirements can be found in Humana's provider manual at www.humana.com/provider/news/publications.

7.
Access to care requirements

Access to care requirements

Participating primary care physicians (PCP) are required to ensure adequate accessibility for healthcare 24 hours per day, seven days per week and may not discriminate against enrollees. An after-hours telephone number must be available to enrollees, voicemail is not permitted. Enrollees should be triaged and provided appointments for care within the time frames listed on the following slide.

Access to care requirements (cont'd)

Primary care providers	
Patients with:	**Should be seen:**
Emergency needs	Immediately upon presentation; 24 hours a day, seven days a week
Urgent care	Not to exceed 48 hours from date of an enrollee's request
Routine care needs	Not to exceed 30 days from date of an enrollee's request
NonPCP specialists	
Patients with:	**Should be seen:**
Emergency needs	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

Access to care requirements (cont'd)

Behavioral health providers	
Patients with:	**Should be seen:**
Emergency care	Must be provided within six hours, crisis stabilization
Care for non-life-threatening emergency	Within six hours
Urgent care	With 48 hours
Routine office visit	Shall not exceed 10 business days
Post discharge from an acute psychiatric hospital	Within seven days, 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 times must not exceed 30 days for regular appointments and 48 hours for urgent care.

Interpretation / Translation services

- All providers are required to abide by federal and state regulations related to sections 504 and 508 of the Rehabilitation Act, Americans with Disabilities Act (ADA), Executive Order 13166 and Section 1557 of the Affordable Care Act (ACA), in the provision of effective communication, including:
  - In-person or video-remote interpretation for deaf patients and over-the-phone interpretation with a minimum 150 languages available for non-English speakers
  - Such services are provided at no cost to the enrollee, per federal law

8.
Referrals and prior authorizations

Referrals

PCPs are enrollees' medical homes and coordinate their care. Enrollees may self-refer to any participating provider; however, Humana encourages enrollees to notify their PCP of other provider visits.

Providers are encouraged to use Screening, Brief Intervention and Referral to Treatment (SBIRT) best practices for all enrollees with a substance-use disorder. For more information on to incorporate SBIRT into your practice, please refer to the Substance Abuse and Mental Health Services Administration (SAMHSA) site at www.integration.samhsa.gov/clinical-practice/sbirt.

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

Prior authorizations

- Humana requires prior authorization for certain services to facilitate care coordination as well as to confirm that the services are being provided according to KDMS coverage policies.

- Enrollee eligibility is verified when a prior authorization is issued; however, treating providers must confirm eligibility on the date of service. Humana is not able to pay claims for services provided to ineligible enrollees.

- Prior authorizations are required for specific services and medications. Please see the Pharmacy section of this presentation for details on drug prior authorizations.

- Physicians and other healthcare providers should review the Kentucky Medicaid Prior Authorization List online at **Humana.com/PAL**.

- Prior authorization for services must be obtained prior to the date of service.

Prior authorizations for medical procedures

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

- Visit the Availity Provider Portal at www.Availity.com

- Call 1-888-285-1114 and follow the menu prompts for authorization requests, depending on your need.

Online authorizations

Online management

- Access to last 18 months of authorization history

- Ability to update authorizations

- Status updates on submitted authorizations

Sign into the secure Availity Provider Portal at
Availity.com

Prior authorization – What should be included in the request?

When requesting authorization, please provide the following information:

- Enrollee/patient name and Humana enrollee ID number
- Provider name, National Provider Identifier (NPI), Tax ID number (TIN) and contact information for ordering/servicing providers and facilities
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits or unit of service requested, if applicable
- Reason for referring to an out-of-plan provider, if applicable
- Clinical information to support the medical necessity of the service, including a current treatment plan and assessments (if applicable)
- 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

Prior authorization – Determination time frames

Standard determination

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

Expedited determination

- When a provider indicates, or Humana 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 should be expedited.

Retrospective review

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 already was 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 a member transitioning from another managed care organization to Humana will be upheld for the remainder of that prior-authorization approval time period.

Retrospective review

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

- Please fax retro-authorization requests to 1-833-974-0059. 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

9.
Claims processing and claims resolution process

Electronic claim submission

Humana payer IDs

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

Avesis payer IDs

- 62224 for dental encounter claims
- 61105 for vision encounter claims

Claims submission before and after Jan. 1, 2020

Coverage type	Current process, through Dec. 31, 2019	New process, effective Jan. 1, 2020
Medical	CareSource	Submit all 2020 medical dates of service to Humana. Humana will reroute 2019 dates of service to CareSource. **Humana payer IDs** Claims: 61101 Encounters 61102 **Submit claims directly and at no cost through** www.availity.com **File paper claims by mail to:** Humana Claims Office P.O. Box 14601 Lexington, KY 40512-4601 **File paper encounters by mail to:** Humana Claims Office P.O. Box 14605 Lexington, KY 40512-4605

Coverage type	Current process, through Dec. 31, 2019	New process, effective Jan. 1, 2020
Behavioral health	Beacon	Humana P.O. Box 14601 Lexington, KY 40512-4601
Dental	Avesis	Avesis No changes in address; please continue to submit as you do today
Vision	Block/Superior Vision Claims paid by CareSource	Avesis ATTN: Humana Health Plan P.O. Box 38300 Phoenix, AZ 85069-8300 www.avesis.com
Chiropractic	Tivity Claims paid by CareSource	Humana P.O. Box 14601 Lexington, KY 40512-4601
Pharmacy	CVS Caremark	Humana

Importance of encounter submissions in Medicaid

KDMS requires all encounters for paid or denied services to be submitted, including the following:

- Services paid at $0

- Fee-for-service and capitated providers

- Appropriate provider registration and documentation

Encounters identify enrollees who have received services.

- Decreases the need for medical record review during Healthcare Effectiveness Data and Information Set (HEDIS)

- Critical to future implementation of Medicaid Risk Adjustment

- Helps identify enrollees receiving preventive screenings and decreases enrollees listed in GAP reports

How to avoid encounter submission errors

How to avoid these errors:

- Confirm the provider information submitted exactly matches the provider information as its registered with KDMS and in accordance with the services provided (e.g., NPI, Medicaid number, taxonomy code, ZIP + 4, provider specialty code, provider type code).

- Ensure that billing and rendering NPIs on the claim are correct and are enrolled/registered with Medicaid and KDMS.

- Ensure billed amounts are not zero dollars (providers must submit billed charges).

How to avoid claims submissions errors

Common rejection or denial reasons:

- Patient not found

- Insured subscriber not found

- Invalid Healthcare Common Procedure Coding System (HCPCS) code submitted

- No authorization or referral found

- Billed amount missing

- National Drug Code (NDC) not covered or invalid

- How to avoid these errors:

  - Confirm that patient information received and submitted is accurate and correct.

  - Ensure that all required claim form fields are complete and accurate.

  - Obtain proper authorizations and/or referrals for services rendered.

  - Ensure billed amounts are not zero dollar.

  - Ensure enrollee has a valid Medicaid ID.

Timely filing

- Claims must be submitted within 180 calendar days of the date of service or discharge.*
- Providers have 180 calendar days from the date of service or discharge to submit a corrected claim or file a claim appeal.
- Delegated encounter claims should be filed to the plan within five calendar days from the date of adjudication by the delegate.
- Claims timely filing and Healthcare Effectiveness Data and Information Set (HEDIS):

  o Providers are required to timely file their claims/encounters for all services rendered to members. Timely filing is an essential component reflected in Humana's HEDIS reporting and can ultimately affect how a plan and its providers are measured in member preventive care and screening compliance.

* Providers should refer to the Humana participating agreement for timely filing requirement terms and exceptions.

Claims payment: Electronic funds transfer (EFT) and electronic remittance advice (ERA)

Receive HIPAA-compliant ERA transactions.

Get paid up to seven days faster than via mail.

Have remittances sent to your clearinghouse, or view them online.

Reduce the risk of lost or stolen checks.

Reduce paper mail and time spent on manual processes.

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

Additional assistance with ERA/EFT setup

Contact us if your organization needs:

Separate remittance information for different providers or facilities.

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

You can reach Humana Provider Service at 1-800-444-9137.

Balance billing

- Per Humana's provider manual:

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

10.
Provider grievance and appeals

Provider education

- Find grievance and appeals (G&A) information in the enrollee handbook and provider manual.

- Humana has a no-wrong-door policy for submission

  o Appeals can be submitted verbally, via telephone or online, etc.

  o Appeals are handled in accordance with Kentucky regulations

- Talk to your provider engagement representative.

What happens when Humana receives a grievance

- Humana acknowledges the receipt of each grievance within five business days to the individual filing the grievance.
- The investigation and final resolution for standard grievances are completed within 30 calendar days.
- What happens if additional time is needed?
  - If the grievance is not resolved within 30 calendar days, Humana will request a 14-day extension to resolve the matter.

What happens when Humana receives an appeal

- Humana acknowledges the receipt of each appeal within five business days.
- For all standard appeals, Humana provides written notice of resolution within the 30-calendar-day time frame.
- What happens if additional time is needed?
  - If the grievance is not resolved within 30 calendar days, Humana will request a 14-day extension to resolve the matter.

Expedited appeal

- Expedited appeals are resolved within 72 hours of the initiation of the expedited appeal process for enrollees.

- What happens if additional time is needed?
  - If the grievance is not resolved within 30 calendar days, Humana will request a 14-day extension to resolve the matter.

Grievances submitted to KDMS

- Grievances submitted directly to KDMS using the state's forms are handled in our Critical Inquiries department.

- All critical inquiries are responded to as requested by KDMS within that specific inquiry.

11.
Continuity of care

Enrollees with special healthcare needs

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

- Humana will provide continuation/coordination of medically necessary covered services for up to 90 calendar days or until the enrollee may be reasonably transferred without disruption, whichever is first.

- Humana may require prior authorization for continuation of the services beyond 30 calendar days; however, under these circumstances, authorization will not be denied solely on the basis that the provider is not contracted with Humana.

Transitioning during pregnancy

- First trimester: Humana will cover the costs of continued medically necessary prenatal care, delivery and postnatal care services without prior authorization and regardless of the provider's contract status until Humana can safely transfer the enrollee to a network provider without impeding service delivery.

- Second and third trimesters: Humana will cover the costs of continued access to the prenatal care provider (whether the provider is contracted or not) for 60 calendar days post-partum, provided the enrollee remains covered through Humana, or referral to a safety-net provider if the enrollee's eligibility terminates before the end of the post-partum period.

Transitioning during pregnancy (cont'd)

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

- Humana will temporarily cover the costs of continuation of such medically necessary services.

- After 30 days, Humana may require prior authorization for continuation of services, but authorization will not be denied at that point solely due to a provider's contract status.

- Humana may continue services uninterrupted for **up to 90 calendar days or until the enrollee may be reasonably transferred without disruption, whichever is less**.

12.
Care management programs

Care management overview

Care management:

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

Humana includes the following steps in its care management:

- Identifies enrollees through referrals from on-site/telephonic UM nurses, PCPs, specialists, enrollee self-referral, health needs assessment, predictive model algorithms, post-discharge assessments, etc.

- Obtains enrollees' permission/agreement to participate. (Enrollees may opt out at any time.)

- Completes a comprehensive assessment incorporating physical and behavioral health as well as social determinants of health.

- Identifies key members of enrollees' interdisciplinary care team and engages the PCP.

- Creates an individualized comprehensive care plan with the enrollee and works toward identified goals.

- Makes available the individualized care plan to providers by contacting Humana or through Availity Provider Portal.

Care management functions

Care management:

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

Humana also:

- Identifies triggers for ER visit/admission and partners with enrollees and their healthcare providers to prevent/reduce ER visits and unplanned inpatient admissions

- Addresses HEDIS measures for enrollees' gap reports or alerts on file

- Refers to internal and external programs and community resources as needed (e.g., maternal health program, smoking cessation, food pantry resources, etc.)

- Coordinates and participates in interdisciplinary team meetings to identify the best course of action for improved outcomes based upon enrollee needs

- Educates enrollees on disease process, self care and value-added benefits, such as vision and dental coverage

- Supports and reinforces medical provider instructions and facilitates appointment scheduling and attendance

Chronic condition management

Programs

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

Enrollee incentive programs

Enrollee incentive programs

Moms First Program – Prenatal, postpartum and well-baby visits

Healthy Behavior incentives – HbA1c check, DRE, microalbumin check, PAP smear, mammogram, PCP well visit within 90 days of enrollment, enrollee follow-up with a practitioner within seven days of psychiatric emergency room visit

- Enrollee incentive programs are healthy behavior programs designed to help enrollees live a healthier lifestyle and maintain health.

- Enrollees can call Humana to find out how to enroll in incentive programs and find out more.

Maternal health and transition programs

Moms First

- Manages prenatal and postpartum enrollees from onset of pregnancy up to eight weeks post-partum or eligibility loss

- Facilitates care coordination with Women, Infants and Children (WIC), Healthy Start and other internal/external programs

Transition Support

- Supports enrollees as they transition out of inpatient care to the community

- Supports follow-up appointments

- Ensures delivery of at-home, post-discharge items

- Reviews discharge instructions and changes to medication

13.
Utilization Management

Health services and utilization management

Utilization management helps maintain the quality and appropriateness of healthcare services provided to Humana enrollees.

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

Utilization management

Front-end review clinician responsibilities:

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

Concurrent nurse responsibilities:

- Completes comprehensive discharge planning assessments on enrollees with inpatient admission.

- Conducts medical-necessity reviews on enrollees with continued inpatient stays.

- Collaborates daily with enrollee's healthcare team to maximize enrollee's benefits and resources and identifies enrollee's anticipated discharge planning needs.

- Conducts medical-necessity reviews for post-acute level-of-care requests in collaboration with medical director.

- Identifies and refers enrollees to internal Humana case management/disease management programs.

- Refers enrollee to community resources or Humana social worker when social issues place enrollee at risk for readmission.

Discharge supports

Case management:

When inpatient discharge notes indicate needs for a Medicaid enrollee, Humana's Case Management collaborates with multiple areas to coordinate care.

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

14.
Pharmacy

Pharmacy benefit summary

Copayments

If subject to a copay, the following apply:

Generics: $1

Brands: $4

OTC: $0 (requires prescription)

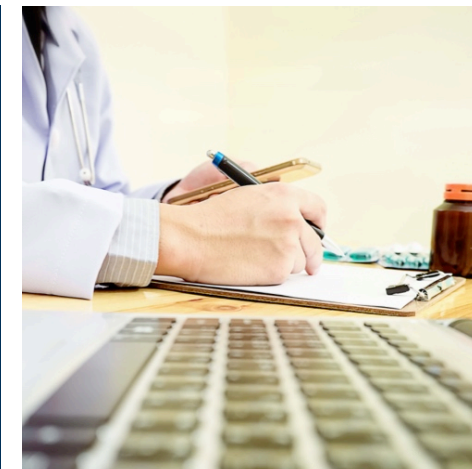## Preferred drug list (PDL)

90-day supply

Select maintenance medications are eligible for 90-day supply at both retail and mail order locations

Medication therapy management (MTM)

MTM is a program to enhance a member's medication therapy and to minimize adverse drug reactions for eligible enrollees

Drug prior authorization and notification

Get forms at Humana.com/pa or call 1-800-555-2546 (Monday through Friday, 8 a.m. to 8 p.m. local time)

- Submit requests electronically by going to www.covermymeds.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).

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

- Obtain forms at Humana.com/medPA
- Submit request by fax to 1-888-447-3430

Prescriber quick reference guide

Authorization process	• Obtain forms at **Humana.com/PA** or submit your request electronically by going to www.covermymeds.com/epa/humana • Submit request by fax to 1-877-486-2621 • Call HCPR at 1-800-555-CLIN (1-800-555-2546)
Requirements for prior authorization fax form	• National Provider Identifier (NPI) • Address of enrollee • Address of prescriber • Time period and outcome of past therapy tried/failed **NOTE:** Include medical records ONLY for medical necessity or off-label-use review (not for every submission)
Questions	**1-800-555-CLIN (1-800-555-2546)**; Monday through Friday, 8 a.m. to 6 p.m., Eastern time
Exceptions by mail	**Medicare:** HCPR, Attn: Medicare Coverage Determination, P.O. Box 33008, Louisville, KY 40232 **Commercial and Medicaid:** HCPR, Attn: Prior Authorizations, P.O. Box 33008, Louisville, KY 40232

Humana Medication Intake Team (MIT)

For medication supplied and administered in a physician's office and billed as a medical claim (Part B for Medicare); also considered medication preauthorization/precertification

Precertification process	• Obtain forms at **Humana.com/medPA** • Submit request by fax to 1-888-447-3430 • View preauthorization and notification lists at **Humana.com/PAL**
Questions	**1-866-461-7273**; Monday through Friday, 6 a.m. to 8 p.m., Eastern time

General Humana contact information

Claims address	Located on the patient's Humana enrollee ID card
Pharmacy appeals	**Commercial and Medicaid:** Humana Appeals, P.O. Box 14546, Lexington, KY 40512-4546; Fax: 1-800-949-2961 **Medicare:** Humana Appeals, P.O. Box 14165, Lexington, KY 40512-4165; Fax: 1-800-949-2961 To file a Part D redetermination online: **Humana.com/providers/pharmacy/exceptions_appeals.aspx**

Humana Pharmacy

Humana Pharmacy® (mail-delivery pharmacy for maintenance medications and durable medical equipment)	**1-800-379-0092** (Fax: 1-800-379-7617), Monday through Friday, 8 a.m. to 11 p.m., Eastern time; Saturday, 8 a.m. to 6:30 p.m., Eastern time; **HumanaPharmacy.com**
Humana Specialty Pharmacy® (mail-delivery pharmacy for specialty medications)	**1-800-486-2668** (Fax: 1-877-405-7940), Monday through Friday, 8 a.m. – 8 p.m. Eastern time; Saturday, 8 a.m. to 6 p.m., Eastern time; **HumanaPharmacy.com/Specialty**
PrescribeIt RX ® (mail delivery for FL Medicaid)	**1-800-526-1490** (Fax: 1-800-526-1491), Monday through Friday, 8 a.m. to 5 p.m., Eastern time; **prescribeitrx.com**

15.
Quality

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** – Consumer Assessment of Healthcare Providers and Systems (CAHPS) , Experience of Care & Health Outcomes (ECHO)
- **Peer review** – Review of provider's practice methods and patterns to determine appropriateness of care.

External quality review organization (EQRO)

Humana is required to participate in periodic medical record reviews. The Commonwealth of Kentucky retains an external quality review organization (EQRO) to conduct medical record reviews for Humana enrollees. You may periodically receive requests from Humana 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).
- Medical chart organization and documentation information is available in Humana's Kentucky Medicaid Provider Manual.

Quality improvement (QI)

Healthcare providers may obtain a written QI program description by calling Provider Services at 1-800-444-9137. We welcome healthcare practitioners' input regarding our QI program.

Feedback can be provided in writing to the following address:

Humana Quality Management Department

321 W. Main St., WFP20

Louisville, KY, 40202

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

16.
Electronic health records

Electronic health records (EHRs)

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

Electronic health records (cont'd)

Advantages of EHRs:

EHRs and the ability to exchange health information electronically can help you provide higher quality and safer care for patients while creating tangible enhancements for your organization. EHRs help providers better manage care for patients and provide better healthcare by:

- Providing **accurate, up-to-date and complete information about patients** at the point of care

- Enabling quick access to patient records for more **coordinated, efficient care**

- **Sharing electronic information** securely with patients and other clinicians

- Helping providers more effectively **diagnose patients, reduce Medicaid errors and provide safer care**

Electronic health records (cont'd)

Advantages of EHRs:

o Improving patient and provider interaction and communication, as well as **healthcare convenience**

o Enabling safer, **more reliable prescribing**

o Helping promote **legible, complete documentation** and accurate, streamlined coding and billing

o Enhancing **privacy and security** of patient data

o Helping providers **improve productivity** and **work-life balance**

Electronic health records (cont'd)

For assistance:

- Regional extension centers

  - If providers need assistance with selecting an EHR system, they can reach out to their local regional extension center (REC). RECs offer unbiased EHR implementation support throughout the implementation process from start to finish. These organizations, funded by the Office of the National Coordinator for Health Information Technology (ONC) also serve as a two-way pipeline to local and federal resources. www.kentuckyrec.com

  - RECs can help with EHR implementation and project management, vendor selection, workflow redesign, privacy and security, training, ongoing technical assistance and more. Visit www.healthit.gov/providers-professionals/get-ehr-implementation-support for more information.

- Kentucky Health Information Exchange (KHIE)

  - If providers need assistance in technically connecting to other providers, they can reach out to the Kentucky HIE (KHIE) or visit khie.ky.gov/Pages/index.aspx. KHIE enables the secure exchange of health information between healthcare providers.

Electronic health record incentive program

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

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

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

17.
Marketing guidelines

Marketing guidelines

- 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.

18.
Additional training requirements and provider responsibilities

Additional training requirements

- Providers must complete additional annual required compliance training on the following topics:

  o General Compliance and Fraud, Waste and Abuse

  o Cultural Competency

  o Health, Safety and Welfare (Abuse, Neglect and Exploitation)

  o Others as required

- These trainings can be located on the following secure provider websites: **Humana.com/providers** and **www.availity.com**.

- **Be sure to complete the "Medicaid Partner Training Attestation" form to ensure completion is documented.**

Advanced directives

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

- The discussion should 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.

19.
Fraud, waste and abuse

Fraud, waste and abuse (FWA) reporting requirement and reporting options

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

- **Telephone:**

  - Special Investigations Unit (SIU) Direct Line: 1-800-558-4444
    (Monday through Friday, 8 a.m. to 4 p.m. Eastern time)

  - 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:** www.ethicshelpline.com

All information will be kept confidential.

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

FWA reporting information (cont'd)

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

- By phone: 1-800-372-2970; Monday through Friday, 8 a.m. to 4:30 p.m. Eastern time
- In writing:

    Kentucky Cabinet for Health and Family Services

    Office of the Inspector General

    Division of Audits and Investigations

    275 E. Main St., 5 E-D

    Frankfort, KY 40621

False Claims Act

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

Disallowed Actions (31 U.S.C. §§ 3729-3733)
Links to the previously mentioned provisions of this act are listed within Humana's Compliance Policy for Contracted Health Care Providers and Business Partners, which is available at Humana.com/fraud.

20.
Web resources

Provider website – public

- Health and wellness programs
- Clinical practice guidelines
- Provider publications (including
- Provider Handbook)

- Pharmacy services
- Claim resources
- Quality resources
- What's new

For questions about and assistance with the Humana.com sites, please call Provider Services at 1-800-444-9137.

Working with Humana online?
Use the multiplayer Availity Provider Portal

The Availity Provider Portal is Humana's preferred method for online transactions.
- ✓ Use one consistent site to work with Humana and other payers
- ✓ Check eligibility and benefits
- ✓ Submit referrals and authorizations
- ✓ Manage claim status
- ✓ Use Humana-specific tools
- ✓ Submit grievances

About Availity

- Cofounded by Humana
- Humana's clearinghouse for electronic transactions (EDI) with providers

21.
Helpful numbers

Helpful numbers

- **Medicaid enrollee/provider service:** 1-800-444-9137

- **Humana's interactive response line (IVR)**: 1-800-444-9137

- **Prior-authorization (PA) assistance for medical procedures and medication billed as medical claim:** 1-888-285-1114

- **Medication intake team (prior authorization for medications administered in medical office):** 1-866-461-7273

- **Prior authorization for pharmacy drugs:** 1-800-555-2546

- **Humana Pharmacy (mail order for maintenance medications)**: 1-800-379-0092

- **Specialty pharmacy:** 1-800-486-2668

- **Medical and behavioral health clinical intake team:** 1-888-285-1114

- **24-hour nurse hotline:** 1-800-648-8097

- **Behavioral health crisis line:** 1-833-801-7355

- **Medicaid care management:** 1-888-285-1121

Helpful numbers (cont'd)

Medicaid care and chronic condition management:
1-888-285-1121

Availity customer service/tech support: 1-800-282-4548

Ethics and compliance concerns: 1-877-5 THE KEY
(1-877-584-3539)

Reporting Medicaid Fraud: 1-800-614-4126

Questions about arranging interpretation services for enrollee appointments: 1-877-320-1235