Humana Medicaid Provider Orientation and Training

Information for Medicaid healthcare providers and administrators

2020 Kentucky
# Training topics

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Training topics are based on the following:

- Humana’s contract with the Kentucky Department of Medicaid Services (KDMS)
- Humana’s policies and procedures
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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
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 Health Plan ID Card](image)

- 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: 1-800-646-8097
- Please visit us at Humana.com
- For online provider services, go to [www.availity.com](http://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 kyommis.com/kyommis/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:

<table>
<thead>
<tr>
<th>Alternative birthing center services</th>
<th>Hearing services, including hearing aids for enrollees younger than 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory surgical center services</td>
<td>Home health services</td>
</tr>
<tr>
<td>Behavioral health services – mental health and substance abuse disorders</td>
<td>Hospice services (non-institutional only)</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Independent laboratory services</td>
</tr>
<tr>
<td>Community mental health center services</td>
<td>Inpatient hospital services</td>
</tr>
<tr>
<td>Dental services, including oral surgery, orthodontics and prosthodontics</td>
<td>Inpatient mental health services</td>
</tr>
<tr>
<td>Durable medical equipment, including prosthetic and orthotic devices and disposable medical Supplies</td>
<td>Meals and lodging for appropriate escort of enrollees</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis &amp; Treatment (EPSDT) screening and special services</td>
<td>Medical detoxification, meaning management of symptoms during the acute withdrawal phrase from a substance to which the individual has been addicted</td>
</tr>
<tr>
<td>End-state renal dialysis services</td>
<td>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</td>
</tr>
<tr>
<td>Family planning services in accordance with federal and state law and judicial opinion</td>
<td>Organ transplant services not considered investigational by FDA</td>
</tr>
</tbody>
</table>
**Covered services (cont’d)**

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

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:

<table>
<thead>
<tr>
<th>Coverage type</th>
<th>Network</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>Avesis</td>
<td>1-888-211-0599</td>
</tr>
<tr>
<td>Vision</td>
<td>Avesis</td>
<td>1-844-511-5760</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Humana</td>
<td><a href="mailto:pharmacycontracting@humana.com">pharmacycontracting@humana.com</a></td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Tivity</td>
<td><a href="mailto:WHNRecruitment@trivityhealth.com">WHNRecruitment@trivityhealth.com</a></td>
</tr>
</tbody>
</table>
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)

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<td>Patients with:</td>
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</tr>
<tr>
<td>Emergency needs</td>
<td>Immediately upon presentation; 24 hours a day, seven days a week</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Not to exceed 48 hours from date of an enrollee's request</td>
</tr>
<tr>
<td>Routine care needs</td>
<td>Not to exceed 30 days from date of an enrollee's request</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>NonPCP specialists</th>
<th>Should be seen:</th>
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<tr>
<td>Patients with:</td>
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<tr>
<td>Emergency needs</td>
<td>Immediately upon presentation</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Not to exceed 48 hours</td>
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<tr>
<td>Routine care needs</td>
<td>Not to exceed 30 days from date of an enrollee's request</td>
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</table>
Access to care requirements (cont’d)

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<th>Behavioral health providers</th>
<th>Should be seen:</th>
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<tr>
<td>Patients with:</td>
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<tr>
<td>Emergency care</td>
<td>Must be provided within six hours, crisis stabilization</td>
</tr>
<tr>
<td>Care for non-life-threatening emergency</td>
<td>Within six hours</td>
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<tr>
<td>Urgent care</td>
<td>With 48 hours</td>
</tr>
<tr>
<td>Routine office visit</td>
<td>Shall not exceed 10 business days</td>
</tr>
<tr>
<td>Post discharge from an acute psychiatric hospital</td>
<td>Within seven days, but may not exceed 14 days*</td>
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</table>

*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.

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

If PCPs need assistance referring enrollees in appropriate behavioral healthcare, Humana’s Case Management team can assist you and the patient. A referral to Medicaid Case Management Form and instructions for submission can be found on the provider website at https://www.humana.com/provider/medical-resources/medicare-medicaid/kentucky-Medicaid.

*Exceptions to this policy apply to enrollees eligible for participation in the Lock-in Program.
Referrals (con’t)

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

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

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

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

For referral and up-to-date openings in facilities for addiction treatment in Kentucky, please visit https://findhelpnowky.org/c/ky.

For more information on how to use SBIRT in your practice, please visit https://www.integration.samhsa.gov/clinical-practice/sbirt.
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 submission**
- Fast and easy entry of authorizations through Availity
- Express entry feature
- Real-time responses
- Ability to add attachments
- Quick-print feature

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

Sign into 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

Claims clearinghouses*

- Availity  www.availity.com  1-800-282-4548
- Change Healthcare (formerly Emdeon)  www.changehealthcare.com  1-800-792-5256
- Waystar  www.waystar.com  1-877-494-7633
- TriZetto  www.trizettoprovider.com  1-800-969-3666
- RelayHealth  www.relayhealth.com  1-800-388-2316
- SSI Group  www.thessigroup.com  1-800-881-2739

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

Resources

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

Humana payer IDs

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

Avesis payer IDs

- 62224 for dental encounter claims
- 61105 for vision encounter claims
<table>
<thead>
<tr>
<th>Coverage type</th>
<th>Current process, through Dec. 31, 2019</th>
<th>New process, effective Jan. 1, 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>CareSource</td>
<td>Submit all 2020 medical dates of service to Humana. Humana will reroute 2019 dates of service to CareSource. <strong>Humana payer IDs</strong> Claims: 61101 Encounters 61102 <strong>Submit claims directly and at no cost through</strong> <a href="http://www.availity.com">www.availity.com</a> <strong>File paper claims by mail to:</strong> Humana Claims Office P.O. Box 14601 Lexington, KY 40512-4601 <strong>File paper encounters by mail to:</strong> Humana Claims Office P.O. Box 14605 Lexington, KY 40512-4605</td>
</tr>
</tbody>
</table>

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

Common reasons for rejection or denial:
• Providers submitting an incorrect NPI/ZIP code/taxonomy code. (Please note: NPI, taxonomy code and ZIP + 4 are referred to as the NPI Crosswalk.)
• Encounters missing NPI/ZIP code/taxonomy code.
• Providers submitting encounters with a billing and/or rendering NPI that is not enrolled/registered for Medicaid with KDMS.
• Providers submitting encounters with zero-dollar billed charges.
• Providers not submitting the correct encounter payer ID.

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

Get paid up to seven days faster than via mail.

Reduce the risk of lost or stolen checks.

Receive HIPAA-compliant ERA transactions.

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

Reduce paper mail and time spent on manual processes.

Learn more, including how to enroll, at Humana.com/epaymentinfo.
Additional assistance with ERA/EFT setup

Contact us if your organization needs:

- Payments deposited in more than one bank account.
- Separate remittance information for different providers or facilities.
- ERA/EFT setup for multiple provider groups, facilities and/or individuals.

You can reach Humana 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

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

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

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

**Preferred drug list (PDL)**
www.humana.com/provider/medical-resources/medicare-medicaid/kentucky-medicaid

**Medication therapy management (MTM)**
MTM is a program to enhance a member’s medication therapy and to minimize adverse drug reactions for eligible enrollees.

Additional Pharmacy Benefit information can be found at Humana.com
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

Humana Clinical Pharmacy Review (HCPR)
For medication supplied by a pharmacy and billed through the pharmacy benefit: medication prior authorization (PA), step therapy, quantity limits and medication exceptions. To view Humana drug list, go to Humana.com/druglists

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

Humana recognizes that your patients have the sole discretion to choose their pharmacy. Also, we support your independent medical judgment when advising patients about their pharmacy choices. Other pharmacies are available in our network. Humana members should check their plan documents to verify their prescription benefits.
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:

- Improving patient and provider interaction and communication, as well as healthcare convenience
- Enabling safer, more reliable prescribing
- Helping promote legible, complete documentation and accurate, streamlined coding and billing
- Enhancing privacy and security of patient data
- Helping providers improve productivity and work-life balance
Electronic health records (cont’d)

For assistance:

• Regional extension centers
  o 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
  o 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)
  o 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.
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)

• **Email:** siureferrals@humana.com or ethics@humana.com

• **Web:** [www.ethicshelpline.com](http://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.
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.

**Liability (31 U.S.C. 3729(a)(1) and (a)(3))**: Liability for the foregoing acts includes:
  - A civil penalty of $5,000-$10,000
  - Three times the amount of damages which the Government sustains because of that act
  - A person or company who violates the False Claims Act is also liable to the government

**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

Humana.com/producers and Humana.com/KentuckyMedicaid

- 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

How to register
- Go to Availity.com

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

Questions
- Availity help with registration and tools: Call 1-800-AVAILITY (1-800-282-4548)
- Questions for Humana: Call Provider Services at 1-800-444-9137

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