Humana
Healthy Horizons®
in Kentucky

Network Notification – Humana Healthy Horizons in Kentucky

Notice date: <Insert notification date here>
To: Humana Healthy Horizons® in Kentucky provider network
From: Humana Healthy Horizons in Kentucky
Subject: Expanded retrospective review policy – revised March 2024
Effective date: January 1, 2024

Effective immediately, Humana Healthy Horizons in Kentucky expands its retrospective review policy to allow for both retrospective enrollee eligibility and provider enrollment time frames.

Definition

A retrospective review is a request for a review for authorization of care, service or benefit for which authorization is required but not obtained before the delivery of care, service or benefit. Humana Healthy Horizons requires prior authorization to ensure covered patients receive medically necessary and appropriate services. Authorization requests that do not meet the necessary criteria as described below are administratively denied. Claims filed for services that require authorization also deny if not authorized.

Retrospective review policy

Humana Healthy Horizons only performs retrospective authorization reviews after a provider request through standard authorization request processes in the following circumstances:

Cause for review	Request time frame requirements
Enrollee was not enrolled with Humana Healthy Horizons on the date of service, but enrollee was retroactively assigned coverage for the date of service through Medicaid enrollment processes.	**Within 12 months from** the date eligibility was updated with Kentucky Department for Medicaid Services.

Cause for review	Request time frame requirements
The service is related to another service that already received prior approval, was already performed, and the new service was not needed at the time the original prior authorized service was performed.	**Within 90 calendar days from:** • The date of service, **or** • The inpatient discharge date, **or** • The initial date of a service, for a service that spans several months, **or** • The date of the primary insurance carrier's Explanation of Payment or authorization denial, which demonstrates the service was not a covered service.
The need for the new service was determined at the performance of the original prior authorized service.	

The exception to this policy applies only to prior authorizations obtained before an enrollee transitions from another managed care organization to Humana Healthy Horizons. Humana Healthy Horizons upholds the approval for 90 days following the transition.

Requests for retrospective review that exceed the time frames and do not meet the criteria outlined above are denied.

What to include when submitting a retrospective review request

- Patient name and Humana ID number
- Authorization number of the previously authorized service for the related request
- Clinical information supporting the service

How to submit a retrospective review request

Providers can submit a retrospective review request for inpatient and outpatient services via:

- **Availity.com** (registration required)
- Phone/interactive voice response: **800-444-9137**
- Fax: 833-974-0059

Providers can view authorization status, along with the authorization number associated with the request at **Availity.com**. Some outpatient authorization requests may auto-approve even when the procedure code may not appear on our preauthorization list (PAL). The Humana Healthy Horizons PAL is available online at **Humana.com/PAL**. Approved service requests are available on Availity.com. Providers may request for written notification when submitting clinical information or by calling **800-444-9137**, Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

If you have any questions about this update to the retrospective review request process, please call Provider Services at **800-444-9137**, Monday – Friday, 8 a.m. – 6 p.m., Eastern time.