# 2023 Provider Manual

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

Humana
Healthy Horizons®
in Ohio

OHHLQGAEN P5721OH1121

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# Introduction

## Welcome and thank you for becoming a participating provider with Humana Healthy Horizons® in Ohio.

We strive to work with our providers to make it as easy as possible to do business with us. This strong partnership helps facilitate a high quality of care and respectful experience for our members.
We are a community-based health plan that serves Medicaid consumers throughout Ohio.

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

As a managed care organization (MCO), Humana Healthy Horizons in Ohio improves the health of our members by utilizing a contracted network of high-quality providers. Primary care providers (PCPs) within the network provide a range of services to our members and coordinate

patient care by referring them to specialists when needed and ensuring timely access to healthcare services and appropriate preventive services.

Humana Healthy Horizons in Ohio distributes member rights and responsibility statements to the following groups after their enrollment and annually thereafter:

- New members
- Existing members
- New providers
- Existing providers

## About Us

Humana is the nation's premier health benefits innovator. We leverage our deep Medicaid experience and capitalize on proven expertise, a diverse suite of resources and capabilities, established relationships and infrastructure. Humana Healthy Horizons in Ohio has the expertise, competencies and resources to make healthcare delivery simpler, while lowering costs and improving health outcomes. Our members receive the highest quality of care and services by offering:

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

## Humana Makes a Difference

Humana brings a history of innovative programs and collaborations to ensure that our members receive the highest quality of care. With a focus on preventive care and continued wellness, our approach is simple: We want to make it easier for our members to get the healthcare they need, when they need it. Through community-based partnerships and services, we help our members successfully navigate complex healthcare systems. Humana has more than 50 years of managed care experience with the expertise and resources that come with it.

**Our services include:**

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

**In addition to the above, our Care Management programs include the following:**

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

## Compliance and Ethics

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

Humana Healthy Horizons in Ohio is committed to conducting business in a legal and ethical environment.

**A compliance plan has been established by Humana Healthy Horizons in Ohio that:**

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

**Following are general compliance and ethics expectations for providers:**

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

For questions about provider expectations, please contact your Provider Relations representative or call Provider Services at **877-856-5707**.
We appreciate your commitment to compliance with ethics standards and the reporting of identified or alleged violations of such matters.

## Accreditation

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

# Basic Plan Information

## General Contact Information

**Provider Services: 877-856-5707**
(7 a.m. to 8 p.m., Monday through Friday)

**24-Hour Nurse Advice Line (24/7/365): 866-376-4827**
**Other helpful phone numbers:**

- Prior authorization (PA) submissions for medical procedures and behavioral health: **800-282-4548**
- Medicaid case management: **877-856-5707**
- Availity customer service/tech support: **800-282-4548**
- Fraud, Waste and Abuse
  - Special Investigations Unit (SIU) Hotline: **800-614-4126** (24/7 access)
  - Ethics Help Line: **877-5-THE-KEY** (877-584-3539)

**Note:** Humana is closed on the following days: New Years Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day.

**Mail**

**Correspondence**
Humana Healthy Horizons in Ohio
P.O. Box 14601 Lexington, KY 40512

**Provider Complaints**
Humana Healthy Horizons in Ohio
P.O. Box 14601
Lexington, KY 40512-4601

**Member Grievance and Appeals Humana Healthy Horizons in Ohio**
P.O. Box 14546
Lexington, KY 40512-4546

**Fraud, Waste and Abuse**
Humana Healthy Horizons in Ohio 1100 Employers Blvd.
Green Bay, WI 54344

## Provider Representative Information

Humana Healthy Horizons in Ohio has knowledgeable provider representatives assigned for each Ohio Medicaid region available to resolve issues raised by providers. Please use the following links to find the provider relations representative in your area:

**Provider Relations Representative Assignment**
**apps.humana.com/marketing/documents.asp?file=4572074**

**Provider Relations Representative Assignment Map by County**
**apps.humana.com/marketing/documents.asp?file=4572061**

# Provider Resources

## Helpful websites

Providers may obtain plan information from **Humana.com/HealthyOH**.

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

- Answers to Frequently Asked Questions
- Availity portal
- Claims & payments
- Communications & network notices
- Documents & resources
- External medical review
- Join our network
- Optimization of pregnancy outcomes
- Pharmacy
- Prior authorization
- Services for children
- Telehealth services
- Training materials

For help or more information regarding web-based tools, please call Provider Services at **877-856-5707**.

## Availity Essentials

Healthcare providers must submit all prior authorization requests and claim submissions through the Availity Essentials portal. Healthcare providers who want to work with Humana Healthy Horizons in Ohio online will need to register to receive the OH ID number for ODM's Provider Network Management (PNM) system. Please go to **ohid.ohio.gov** to create an account or if you would like more information, please visit the **PNM and Centralized Credentialing website at managedcare.medicaid.ohio.gov**. Providers will also need to register for Availity Essentials. This multipayer portal allows providers to interact securely with Humana Healthy Horizons in Ohio and other participating payers without learning to use multiple systems or remembering different user IDs and passwords for each payer. Many tools specific to Humana Healthy Horizons in Ohio are accessible from Availity Essentials. To learn more, call Availity Essentials at **800-282-4548** or visit **Availity.com**. Availity Essentials lets you:

- Submit claims
- Check eligibility and benefits
- View claim status (claim submission, updates and attachments)
- Authorization submission and inquiry (authorization updates and attachments should be submitted via Availity Essentials)
- View remittance advice (electronic remittance advice and electronic funds transfer enrollment should be submitted)
- View member summaries
- Confirm/remedy overpayment
- Confirm/remedy appeal

## Member Enrollment and Eligibility

**Medicaid Eligibility**

Medicaid eligibility is determined by the Ohio Department of Medicaid in the county where the member resides. The Ohio Department of Medicaid provides eligibility to Humana Healthy Horizons in Ohio on a daily basis via an 834 file. Eligibility begins on the first day of each calendar month for consumers joining Humana Healthy Horizons in Ohio.

## Newborn Enrollment

Humana Healthy Horizons in Ohio begins coverage of newborns on the date of birth when the newborn's mother is a member of Humana Healthy Horizons in Ohio. Although a prior auth for the delivery is not required, the notification of birth is required. The delivery hospital is required to complete and send this form **Humana Healthy Horizons in Ohio Medicaid Notification** of Birth to our UM department within 24-business hours of the delivery. Instructions are included on the form. Once a newborn is enrolled, you may verify eligibility for the newborn on the provider portal at Availity.com. Please refer to the Verify Eligibility section for instructions.

## Disenrollment

Members are disenrolled from Humana Healthy Horizons in Ohio for a number of reasons. If a member loses Medicaid eligibility, they lose eligibility for Humana Healthy Horizons in Ohio benefits. Humana Healthy Horizons in Ohio, DCBS or the member can initiate disenrollment.

Member disenrollment can be initiated for the following reasons:

- Unauthorized use of a Member ID Card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the ability to deliver care to the member or other patients

Please notify member services if one or all of the previously listed situations occur. Please see the section below for procedures for dismissing noncompliant members from your practice. We can counsel the member, or in severe cases, initiate a request to DCBS for disenrollment. DCBS reviews each member disenrollment

requests and determines if the request should be granted. Disenrollment from Humana Healthy Horizons in Ohio always occurs at the end of the effective month.

## Involuntary Dismissal

Participating providers can request that a Humana Healthy Horizons in Ohio member be involuntarily dismissed from their practice if a member does not respond to recommended patterns of treatment or behavior.

Examples include:

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

When a member misses three or more consecutive appointments, providers may request assistance from the Humana Healthy Horizons in Ohio Care Management department by sending an email to **OHMCDCaseManagement@humana.com**. Humana Healthy Horizons in Ohio requires that a provider's office make at least three attempts to educate the member about noncompliant behavior and document them in the patient's record. Please remember that Humana Healthy Horizons in Ohio can assist you in educating the member. After three attempts, providers may initiate dismissal procedures using the following guidelines:

- The provider's office must notify the member of the dismissal by certified letter. The letter should include the reason for which the disenrollment is requested and the specific dates of the three documented unsuccessful education attempts.
- A copy of the letter must be sent or faxed to Humana Healthy Horizons in Ohio via the following methods:
  **Humana Provider Relations**
  Grievance and Appeal Department
  P.O. Box 14546
  Lexington, KY 40512-4546
  Fax: 800-949-2961

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

- The member must contact Humana Healthy Horizons in Ohio member services to choose another PCP
- The reason for which the disenrollment is requested should include at least one of the following:
  - Incompatibility of the PCP-patient relationship
  - Patient has not utilized a service within one year of enrollment in the PCP's practice and includes the specific dates of documented unsuccessful contact attempts by mail and phone on at least six separate occasions during the year
  - Inability to meet the medical needs of the patient
- The dismissing PCP serves the affected patient until a new PCP can serve the patient, barring ethical or legal issues.

## Referrals for Release due to Ethical Reasons

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

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

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

The letter should include:

- Reason for the disenrollment request
- Referral to another provider licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition (The provider must be actively enrolled with the State to provide Medicaid services to beneficiaries and must be in Humana Healthy Horizons in Ohio's provider network)
- Instructions to contact Humana Healthy Horizons in Ohio member services at **877-856-5702** for assistance in finding a preferred in-network provider.
- A copy of the letter must be sent or faxed to Humana Healthy Horizons in Ohio at the following address:
  **Humana Provider Relations**
  Grievance and Appeal Department
  P.O. Box 14546
  Lexington, KY 40512-4546
  Fax: 800-949-2961

Please call Provider Services at **877-856-5707** if you have questions about disenrollment reasons or procedures.

## Automatic Renewal

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

## New Member Kits

Each new member household receives a new member kit and an ID card for each person in the family joining Humana Healthy Horizons in Ohio. New member kits are mailed separately from the ID card.

The new member kit contains:

- Welcome letter
- Information on how to obtain a copy of the Humana Healthy Horizons in Ohio Provider Directory
- An Member Handbook which explains how to access plan services and benefits
- A health risk assessment survey
- Member continuity of care form
- Other preventive health education materials and information

## Member ID Cards

All new Humana Healthy Horizons in Ohio members receive a Humana Healthy Horizons in Ohio member ID card. A new card is issued only when the information on the card changes, if a member loses a card or if a member requests an additional card.

The member ID card is used to identify a Humana Healthy Horizons in Ohio member; it does not guarantee eligibility or benefits coverage. Members may disenroll from Humana Healthy Horizons in Ohio and retain their previous ID card. Likewise, members may lose Medicaid eligibility at any time. Therefore, it is important to verify member eligibility prior to every service. Please refer to the Verify eligibility section of this manual for more information.

- **Member name**
- **Date of birth** – Member's date of birth
- **Humana Healthy Horizons in Ohio Member Plan ID Number**
  - Members' Humana Healthy Horizons in Ohio plan identification number
  - Do not use this number to bill Humana Healthy Horizons in Ohio. (Begins with a "H")
- **Medicaid Member ID Number** – Use this number for Ohio Medicaid member identification on claims submitted to Humana (Begins with a "number")
- **Primary care provider/clinic name** – Each member chooses a participating provider to be his or her primary care provider (PCP). If a choice is not made, a PCP is assigned.
- **Member Services** – Phone number and TTY for the hearing impaired.
- **24-hour Nurse Advice Line** – Phone number to reach a registered nurse 24/7/365
- **Behavioral Health Hotline** – Members can call this hotline 24 hours a day, seven days a week and 365 days a year for mental health or addiction services.
- **Website** – Our website contains plan information and access to special functionality, like eligibility verification, claim and prior authorization submission, Coordination of Benefits (COB) check and more.
- **Provider Services** – Use this toll-free phone number if you have questions or wish to verify eligibility over the phone.
- **Pharmacy** – Call Provider Services if you have questions about pharmacy benefits and services.

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

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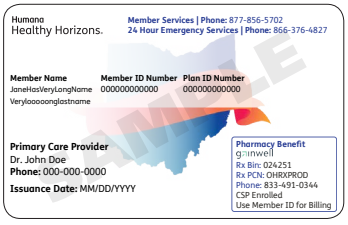


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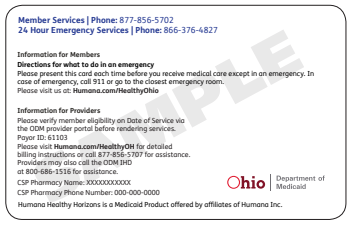


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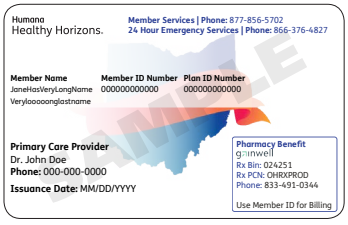


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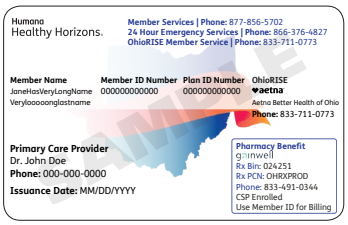


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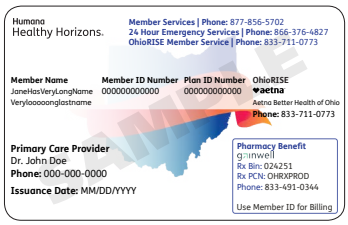


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## Member Support Services and Benefits

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

## Member Services

Humana Healthy Horizons in Ohio can assist members who have questions or concerns about services, such as case management, disease management, nonemergency transportation coordination as well as regarding benefits. Representatives are available by telephone at **877-856-5702** Monday through Friday, 7 a.m. to 8 p.m. Eastern Time, except on observed holidays. If the holiday falls on a Saturday, we will be closed on the Friday before. If the holiday falls on a Sunday, we will be closed the Monday after.

## 24-hour Nurse Advice Line

Humana Healthy Horizons in Ohio's Nurse Advice Hotline offers 24 hour, 7 days per week access to health information and medical triage services to Humana Healthy Horizons in Ohio members. Members have access to the free service by calling **866-376-4827**. Services offered through the Nurse Advice Hotline include:

- Access to a Nurse available to answer health-related questions via telephone, systematic assessment of symptoms, and recommendations for the most appropriate treatment, clinical resources and care setting (e.g., home, virtual consultation, retail clinic, doctor's office, urgent care, ER, etc.).
- Urgent and non-urgent care advice
- Health and wellness education, reminders and resources
- Condition, procedure and treatment explanations
- Medication information, including drug interactions, appropriate use, and adherence benefits and strategies

## Emergency and Crisis Behavioral Health Hotline

**Behavioral Health Crisis Hotline**

The Ohio Department of Mental Health and Addiction Services' (OMHAS) statewide crisis line called, The Ohio CareLine, is a toll-free emotional support call service administered in community settings. Behavioral health professionals staff the CareLine 24 hours a day, 7 days/ week. They offer confidential support in times of personal or family crisis when individuals may be struggling to cope with challenges in their lives. When callers need additional services, they will receive assistance and connection to local providers. Members have access to this service by calling the Ohio Careline directly at **988** or texting "4hope" to 741-741.

If the member calls Humana Healthy Horizons in Ohio directly, we operate a 24 hour, 7 days per week system to route emergent and crisis behavioral health calls directly to the Ohio Department of Mental Health and Addiction Services' (OMHAS) statewide crisis line

As needed, Humana Healthy Horizons in Ohio will collaborate with ODM and OMHAS to ensure OMHAS' statewide crisis line will have access to deploy Mobile Response and Stabilization Services (MRSS) providers when necessary.

## Listserv Subscriptions

**Sign-up to receive news and information from the Ohio Department of Medicaid: medicaid.ohio.gov/wps/portal/gov/medicaid/home/govdelivery-subscribe**

**Center of Medicare & Medicaid Services - Medicaid.gov: public.govdelivery.com/accounts/USCMSMEDICAID/subscriber/qualify**

**Council for Affordable Quality Healthcare, Inc. (CAQH) newsletter sign up: caqh.org/solutions/sanctionstrack**

## Claims Payment Systemic Error (CPSE) Report

A CPSE is defined as the MCO's claims adjudication incorrectly underpaying, overpaying, or denying claims that impact five or more providers. A report containing all active CPSEs is updated monthly and can be found here: **apps.humana.com/marketing/documents.asp?file=4572048**

## Provider Advisory Council

The Humana Healthy Horizons in Ohio Provider Advisory Council (HUM OH PAC) analyzes and evaluates results from provider forums to recommend policy decisions, institutes needed action to address deficiencies, and ensures appropriate follow-up occurs.

HUM OH PAC allocates a forum for members of the committee to engage in review, coordination and direction of the Humana Healthy Horizons in Ohio provider network. The committee is charged with overseeing provider concerns and measurement of quality activities on a regular basis.

The HUM OH PAC will select a wide array of provider types to participate, including dental and behavioral health providers. Meetings are held no less than semi-annually, and attendees can attend in person, phone, or by webinar. The HUM OH PAC will discuss varying topics that will enable Humana to gather input, discuss and learn about issues affecting providers, identify challenges and barriers, problem-solve, share information, and collectively find ways to improve and strengthen the health care service delivery system.

## Provider Policies

The Humana Healthy Horizons in Ohio Provider Manual is the primary source for providers to obtain information regarding Humana policy and procedures. Humana will send network providers bulletins and post policy notices at **Humana.com/OHNotices** to advise network and out-of-network providers of changes to policy and procedure.

## Provider Services Call Center Information

**Provider Services: 877-856-5707** (Hours of operation are Monday through Friday, 7 a.m. to 8 p.m., Eastern time)

**Note:** Humana is closed on the following days: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day.

## Provider Trainings

**Education**

Humana Healthy Horizons in Ohio will conduct an initial educational orientation (either online or in-person) for all newly contracted providers. Additional training will be scheduled to provide targeted education as needed and when requested by providers.

**Provider education of required compliance-based materials**

Providers are expected to adhere to all Humana-identified compliance-based training programs. This adherence includes a completed attestation to agreement by all participating providers and staff members trained on compliance material. The training includes the following required annual training modules:

**Humana orientation**

- Medicaid provider orientation
- Cultural competency
- Health, safety and welfare education
- General compliance training

**Online training modules**

Providers and their office staff can access these online training modules 24 hours a day, seven days a week at Availity Provider Portal, **Availity.com**. Providers also can manually complete the training by visiting **Humana.com/providercompliance**.

If an individual provider is not directly contracted with Humana, but is employed or contracted by a provider entity contracted with Humana, the individual provider:

- Still must complete the training
- Does not have to submit an attestation to Humana

It is the responsibility of the contracted entity to track the training completion of each individual supporting Humana. Providers are expected to train all staff members on the following two topics, although no attestation is required:

- Fraud, waste and abuse
- General compliance

Providers also must adhere to requirements outlined in Humana's policies on compliance and standards of conduct.

For additional provider training visit: **Humana.com/provider/medical-resources/self-service-portal** and choose "Web-based Training Schedule"

**Note:** Humana's separate Compliance Policy and Standards of Conduct documents are available for review and download on the following education page: **Humana.com/fraud**.

## Forms

- Link to ODM Forms Page - **https://medicaid.ohio.gov/stakeholders-and-partners/legal-and-contracts/forms/forms**
- Consent Form - Humana.com/OHDocuments
- Hysterectomy, Abortion, or Sterilization Form(s)
  - Abortion certification form - **apps.humana.com/marketing/documents.asp?file=4490018**
  - Instructions for completing the Abortion certification form - **apps.humana.com/marketing/documents.asp?file=4490005**
  - Acknowledgement of hysterectomy information - **apps.humana.com/marketing/documents.asp?file=4490044**
  - Instructions for completing the Acknowledgement of hysterectomy information - **apps.humana.com/marketing/documents.asp?file=4490031**
  - Consent for sterilization - **apps.humana.com/marketing/documents.asp?file=4490070**
- Standardized Appeal Form - **apps.humana.com/marketing/documents.asp?file=4572022**
- SUD Residential Treatment Notification of Admission form - **https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM10294Fillx.pdf**
- Medicaid Addendum - **medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/mc-policy/managed-care-program-appendix/managed-care-program-addenda**.
- Out-of-Network Provider Application - **https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM10282Fillx.pdf**
- Ohio Medicaid Provider Agreement - **https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM10283Fillx.pdf**

# Provider Responsibilities

## Health Insurance Portability and Accountability Act (HIPAA) and Protected Health Information (PHI)

**Personally Identifiable Information and Protected Health Information**

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

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

Here are some important places to start:

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

**Member Privacy**

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

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

## Provider Obligations for Oral Translation, Oral Interpretation, and Sign Language Services

Providers are required to provide, oral interpretation, oral translation services and sign language assistance at no cost.

Hospital and nonhospital providers are required to abide by federal and state regulations related to the sections 504 and 508 of the Rehabilitation Act, Americans with Disabilities Act (ADA), Executive Order 13166 and Section 1557 of the Affordable Care Act (ACA) in the provision of effective communication. These provisions include in-person or video-remote interpretation for deaf patients and over- the-phone interpretation with a minimum 150 languages available for non-English speakers.

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

## Cultural Competency and Linguistics Services

Cultural competency information as well as languages spoken by office location, are collected in ODM's Provider Network Management (PNM) system and are utilized to populate ODM's centralized provider directory. Additionally, this information for credentialed providers is transmitted to the managed care organizations on a weekly basis for them to align their directories with the information contained in the PNM.

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

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

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

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

Communication is paramount in delivering effective care. Mutual understanding may be difficult during cross-cultural interaction between patients and providers.

Some disparities may be attributed to miscommunication between providers and patients, language barriers, cultural norms and beliefs and attitudes that determine healthcare-seeking behaviors. Providers can address racial and ethnic gaps in healthcare with an awareness of cultural needs and an effort to improve communication with a growing number of diverse patients.

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

A copy of Humana's Cultural Competency Plan is provided at no charge to the provider. Humana's Cultural Competency Plan can be viewed at **docushare-web.apps.cf.humana.com/Marketing/docushare-app?file=3027154**. To request a paper copy, please contact Humana Healthy Horizons in Ohio Provider Services at **877-856-5707**. Humana also offers training material on this topic at **Humana.com/providercompliance**.

**Clear Communication**

Limited English proficiency (LEP) describes how the degree to which a member's inability or a limited ability to speak, read, write, or understand the English language affects effective interactions between the member and healthcare providers or health plan members.

**Language Assistance Program (LAP) for Limited English Proficient (LEP) members**

Humana Healthy Horizons in Ohio is committed to providing free language assistance services for its members with LEP.

This assistance includes:

- Free interpretation services for all languages. Providers may call Humana Healthy Horizons in Ohio at the phone number listed on the member's Humana ID card to access interpretation services while the member is in the office.
- Spanish versions of Humana's non-secure website and member materials
- TTY/TDD services

Members are given the opportunity to request to have a written translation of Humana documentation mailed to them. Members should call the member service phone number listed on the back of the member's Humana ID card to request translated materials.

**Subcultures and Populations**

Subculture is a term that describes ethnic, regional, economic or social groups that exhibit characteristic behavior patterns that distinguish them from others within an embracing culture or society. Understanding the many different subcultures that exist within our own culture also is an important aspect of cross-culture healthcare.

To address the health issues within different ethnicities, providers must work to understand the values, beliefs, and customs of these different people. Some of the cultural aspects that may impact health behavior are:

- Eye contact – Many cultures use deferred eye contact to show respect. Deferred eye contact does not mean that the patient is not listening to you.
- Personal space – Different cultures have varying approaches to personal space and touching. Some cultures expect more warmth and hugging when greeting people.
- Respect for authority – Many cultures are very hierarchical and view doctors with a lot of respect. These patients may feel uncomfortable questioning doctors' decisions or asking questions.

**Health Literacy**

Health literacy describes a member's ability to obtain, process, and understand basic health information and services needed to make appropriate decisions. Over a third of patients experience limited health literacy, which results in a lack of understanding of what's required to care for their health.

Limited health literacy is associated with:

- Poor management of chronic diseases
- Poor understanding of and adherence to medication regimens
- Increased hospitalizations, and poor health outcomes

Humana Healthy Horizons in Ohio develops member communications based on health literacy and plain language standards per the federal Plain Writing Act of 2010. The reading ease of Humana Healthy Horizons in Ohio written member materials is tested using the widely recognized Dale-Chall Readability tool.

**Seniors and People with Disabilities**

Humana Healthy Horizons in Ohio develops individualized care plans that include consideration of special and unique member needs in accordance with the Americans with Disabilities Act (ADA). People with disabilities must be consulted before an accommodation is offered or created on their behalf. Some considerations in treating seniors and people with disabilities include:

- Disease and multiple medications
- Caregiver burden/burnout

- Cognitive impairment and mental health
- Visual impairment
- Hearing impairment
- Physical impairment

Use of clear signage throughout provider offices. Adequate handicapped parking also is required.

**Provider Rights**

Each healthcare provider who contracts with ODM or subcontracts with Humana Healthy Horizons in Ohio to furnish services to Humana Healthy Horizons in Ohio members shall be assured of the following rights:

1. A healthcare professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a Humana Healthy Horizons in Ohio member for the following:
   a) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
   b) Any information the member needs to decide among all relevant treatment options
   c) The risks, benefits, and consequences of treatment or non-treatment
   d) The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions
2. To receive information on the grievance, appeal and fair hearing procedures.
3. To have access to the Humana Healthy Horizons in Ohio's policies and procedures covering the authorization of services.
4. To be notified of any decision by Humana Healthy Horizons in Ohio to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
5. To challenge, on behalf of Humana Healthy Horizons in Ohio members, the denial of coverage of, or payment for, medical assistance.
6. Humana Healthy Horizons in Ohio's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
7. To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

**HealthTrack**

HealthTrack is a database operated by the Ohio Department of Medicaid that tracks member and provider complaints. Providers may file a complaint with ODM and Humana Healthy Horizons in Ohio will receive notice of the complaint through HealthTrack. Within five business days of receipt of a complaint, Humana Healthy Horizons in Ohio will notify the provider (verbally or in writing) that the complaint was received. Humana Healthy Horizons in Ohio will research the complaint and contact the provider to present our findings within 15 business days. If additional time to resolve a complaint is needed past 15 business days, then Humana Healthy Horizons in Ohio will advise the provider of the delay and request an extension from ODM. Humana Healthy Horizons in Ohio will notify the provider and ODM of the resolution within the required time frame.

**Provider Responsibilities**

- Meet compliance and ethics expectations:
  - Have an effective compliance program in place
- Review and adhere to the requirements outlined within these separate Humana documents updated annually:
  - Ethics Every Day for Contracted Healthcare Providers and Third Parties
  - Compliance Policy for Contracted Healthcare Providers and Third Parties
- Adopting the preceding documents, or having materially similar content in place, along with supporting processes, to create a strong foundation to year-over-year compliance. These documents can be accessed at Humana.com/providercompliance
- Act according to professional ethics and business standards
- Conduct exclusion screenings prior to hire/contract and monthly thereafter of those slated to support Humana Healthy Horizons in Ohio, promptly remove any excluded party from supporting us and notify us in a timely manner of the exclusion and action(s) taken
- See Definitions section for more information about the following related terms and/or online resources:
  - Exclusion
  - List of Excluded Individuals/Entities (LEIE)
  - System for Award Management (SAM)
- Complete separate, required trainings on multiple topics and, when required, submit at an organization-level attestation certifying completion
- Additional, related information is in the Required Training section
- Take disciplinary action when your organization or we identify noncompliance, fraud or abuse
- Notify us in a timely manner of suspected violations, misconduct or fraud, waste and abuse concerns and action(s) taken
- Cooperate fully with any investigation of alleged, suspected or detected violations of applicable state or federal laws and regulations

- Maintain current contact information (e.g. service address) and key identifying information (e.g. NPI and Ohio Medicaid ID) in ODM's Provider Network Management (PNM) system
- Notify us if you have questions or need guidance for proper protocol

**Primary Care Provider (PCP) Care Coordination**

The PCP shall serve as the member's initial and most important point of interaction with the plan's provider network. A PCP shall be an individual physician, advance practice nurse practitioner or physician assistant within the specialty types of family/general practice, internal medicine, pediatrics and obstetrics/gynecology (OB/GYNs). The PCP is the member's point of access for preventive care or an illness and may treat the member directly, refer the member to a specialist (secondary/tertiary care), or admit the member to a hospital.

- All Humana Healthy Horizons in Ohio members choose or are assigned to a PCP on enrollment in the plan.
- Members select a PCP from the Humana Healthy Horizons in Ohio's Provider Directory.
- Members have the option to change to another participating PCP as often as needed.
- Members initiate the change by calling Member Services. PCP changes are effective on the first day of the month following the requested change.

**PCPs shall:**

- Comply with the following triage requirements:
  - Members with emergency care needs must be triaged and treated immediately on presentation at the PCP site
  - Members with persistent symptoms must be treated no later than the end of the following working day after their initial contact with the PCP site
  - Members with requests for routine care must be seen within six weeks.
- PCP care coordination responsibilities include, at a minimum, the following:
  - Assist with coordination of the member's overall care, as appropriate for the member;
  - Provide services which are medically necessary as described in rule 5160-1-01 of the Administrative Code;
  - Serve as the ongoing source of primary and preventative care;
  - Recommend referrals to specialists, as required
  - Triage members as described in previous bullet.

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

- Treat Humana Healthy Horizons in Ohio members with the same dignity and respect afforded to all patients – including the same high standards of care and operating hours.
- Managing and coordinating the medical and behavioral healthcare needs of members to ensure that all medically necessary services are made available in a timely manner.
- Referring patients to specialists/subspecialists groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available; communicating with all other levels of medical care to coordinate and follow up on care delivered to patients.
- Maintaining a medical record of all services rendered by the PCP and a record of referrals to other providers and any documentation provided by the rendering provider to the PCP for follow-up and/or coordination of care.
- Developing a Plan of Care to address a patient's risks and medical needs and other responsibilities as defined in this section.
- Working with Humana Healthy Horizons in Ohio Case Managers to develop Plans of Care for members receiving care management services.
- Conducting screens for common behavioral issues, including, but not limited to, depression, anxiety, trauma/adverse childhood experiences (ACEs), substance use, early detection, identification of developmental disorders/delays, social-emotional health, and social determinants of health (SDoH) to determine whether the member needs behavioral health services.
- Providing phone coverage for handling patient calls 24 hours a day, seven days a week.
- Following all prior authorization policies and procedures as outlined in this Manual.
- Complying with the quality standards of Humana Healthy Horizons in Ohio and the ODM as outlined in this Manual.
- Discussing advance medical directives with all members as appropriate.
- Obtaining patient records from facilities visited by Humana Healthy Horizons in Ohio patients for emergency or urgent care, if notified of the visit.
- Ensuring demographic and practice information is up to date for directory and member use.
- Understanding and agreeing that provider performance data can be used by Humana Healthy Horizons in Ohio.
- Transferring information using one or both of Ohio's health information exchanges (HIE).

**Comprehensive Primary Care (CPC)**

- CPC practices must offer at least one alternative to traditional office visits to increase access to patient care team and clinicians in ways that best meet the needs of the population, i.e. e-visits, phone visits, group visits, home visits, alternate location visits or expanded hours in the early mornings, evenings and weekends.
- Must provide access to a PCP with access to the member's medical record within 24-hours of initial request.
- The practice also must make clinical information of the member available through paper or electronic records, or telephone consultation to on-call staff, external facilities and other clinicians outside the practice when the office is closed.

## Release Due to Ethical Reasons

Humana Healthy Horizons in Ohio providers are not required to perform treatments or procedures that are contrary to the provider's conscience, religious beliefs or ethical principles, in accordance with 42 C.F.R. 438.102. Providers should notify Humana Healthy Horizons in Ohio of treatments or procedures that they don't provide due to ethical reasons by submitting an email to the following email addresses:

- **Medical providers: OhioNetworkSpecialist@humana.com**
- **Behavioral health providers: OHBHMedicaid@humana.com**

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

## Required Training

We expect adherence to all training programs identified as compliance-based by the contract and the Ohio Medicaid Managed Care Program. This includes ODM delivered provider training as mandated by ODM and agreement and assurance that training on identified compliance material is conducted by your organization for all affiliated participating providers, supporting healthcare practitioners and staff with member interaction*.

*Member interaction can involve any of the following: face-to-face and/or over the phone conversation, as well as review and/or handling of member or member-related correspondence via mail, email or fax.

All new providers receive Ohio Medicaid Managed Care Program orientation education.

Additionally, compliance training must be conducted by your organization on the following topics on contract/hire and annually thereafter for those supporting Humana Healthy Horizons in Ohio:

- General compliance**
- Combating fraud, waste and abuse (FWA)**
- Humana orientation
- Medicaid provider orientation
- Cultural competency
- Health, safety and welfare/abuse, neglect and exploitation of members

**Your organization may be responsible for developing or adopting another organization's training on the separate topics of general compliance and combatting FWA.

**Note:** An attestation at the organization level must be submitted annually to us, on request, to certify that your organization has a plan in place to comply with and conduct training on any or all of the above topics.

The training on the topics outlined above is designed to ensure the following:

- Sufficient knowledge of how to effectively perform the contracted function(s) to support the membership of Humana Healthy Horizons in Ohio
- The presence of specific controls to prevent, detect and/or correct potential, suspected or identified noncompliance and/or fraud, waste or abuse

Online Humana training modules for the topics listed above, as well as an organization-level attestation form, can be accessed 24/7 within the Availity Provider Portal at **Availity.com** or by anyone at **Humana.com/providercompliance**.

For additional provider training: Visit **Humana.com/HealthyOH** or **Humana.com/provider/medical-resources/self-service-portal** and choose "Web-based Training Schedule"

**Required Provider Identifiers**

All providers must be eligible for participation in the Medicaid program. If a provider is currently suspended or involuntarily terminated from the Ohio Medicaid program, whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider.

It is a provider's responsibility to ensure it is fully enrolled with Ohio Medicaid. Each provider is required to have a National Provider Identifier (NPI) in accordance with Section 1173 (b) of the Social Security Act, as enacted by Section 4707 (a) of the Balanced Budget Act of 1997.

Humana Healthy Horizons in Ohio may deny reimbursement for covered services if it determines that the provider does not have a current Ohio Medicaid provider number at the time it adjudicates the claim.

## Procedure to notify Managed Care Organization of Changes to Provider Practice

As a contracted provider, notifying Humana Healthy Horizons in Ohio of legal and demographic changes is required and ensures provider directory and claim processing accuracy. Examples of changes that require notification include:

- Change to the Tax Identification Number (TIN)
- New providers added to group
- Providers leaving group
- Service address changes, i.e., new location, phone or fax numbers
- Access to public transportation
- Standard hours of operation and after hours
- Billing address updates
- Credentialing updates
- Panel status
- Gender
- Languages spoken in office

Notification of changes should be sent to:

- Medical providers at **OhioNetworkSpecialist@humana.com**
- Behavioral health providers at **OHBHMedicaid@humana.com**

## Advance Medical Directives

The Patient Self-Determination Act of 1990 and state law provide every adult member the right to make certain decisions concerning medical treatment. Members have the right, under certain conditions, to decide whether to accept or reject medical treatment, including whether to continue medical treatment that would prolong life artificially. All providers have the responsibility to discuss advance medical directives with adult members at the first appointment or visit, consistent with 42 CFR Part 489 Subpart I. The discussion should subsequently be charted in the permanent medical record of the member. A copy of the advance directive should be included in the member's medical record inclusive of other mental health directives.

If the member is incapacitated at the time of admission or at the start of care and is unable to receive information (due to the incapacitating conditions or a mental disorder) or articulate whether or not he or she has executed an advance directive, then the provider may give advance directive information to the member's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated member or to a surrogate or other concerned persons in accordance with state law. The provider is not relieved of its obligation to provide this information to the member once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the member directly at the appropriate time.

Providers should discuss potential medical emergencies with the member and document that discussion in the member's medical record.

- All member records shall contain documentation that the member was provided with written information concerning the member's rights regarding advance directives (written instructions for living will or power of attorney), including whether the member has executed an advance directive (42 CFR 438.3(j)(3));
- Neither the managed care plan, nor any of its providers shall, as a condition of treatment, require the member to execute or waive an advance directive (42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5)).

## Value-Based Payment (VBP) Programs

Humana Healthy Horizons in Ohio is committed to fostering high-value care in the communities we serve. Humana Healthy Horizons participates in the Ohio Department of Medicaid's VBP models, including Comprehensive Primary Care (CPC) and CPC for Kids. To learn more about these programs, please reach out to your Provider Relations or Engagement Representatives, or visit: **medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/payment-innovation/payment-innovation**.

In addition to ODM's VBP models, Humana Healthy Horizons in Ohio network providers can participate in a variety of value-based programs that allow them to earn financial incentives and rewards based on quality, cost, and clinical outcomes. The programs are designed based on the provider's panel size and readiness, as well as participation in ODM's programs or other specific contracting arrangements. Program terms and metrics are reviewed annually and modified as appropriate. Any earned performance-based payments are made in arrears to allow for reporting and data collection. To learn more about Humana Healthy Horizons in Ohio's available VBP programs, please contact your provider relations or engagement representatives.

## Ohio Health Information Exchange

ODM requires that all Humana Healthy Horizons in Ohio providers participate with one or both of Ohio's health information exchanges (HIEs). HIEs provides a common, secure electronic information infrastructure that meets national standards to ensure interoperability across various health systems, while affording providers the functionality to support preventive health and disease management. Providers connected to HIE are capable of exchanging protected health information, connecting to inpatient and ambulatory electronic health records, connecting to care coordination information technology system records and supporting secure messaging or electronic querying between providers, patients, and the health plan. This includes, but not limited to, using the HIEs for admission, discharge, and transfer (ADT) data and closing referral loops for SDOH.

Hospitals are required to provide ADT data to both Ohio HIEs.

Information on the Ohio HIEs can be found on the following websites:
CliniSync – **clinisync.org**
Healthbridge – **healthcollab.org**

## Abuse, Neglect and Exploitation

**Reporting Abuse, Neglect and Exploitation**

Ohio providers must report when there is reasonable cause to believe abuse, neglect, exploitation, misappropriation of greater than $500, or unexplained death has occurred to a member. You can contact us at **877-856-5707** and the appropriate Ohio agency:

- Reports of adult abuse can be made to local adult protective services or by calling 855-OHIO-APS (**855-644-6277**) 24 hours a day, seven days a week.
- To report suspected abuse or neglect of a child, call the state of Ohio child abuse reporting directory, toll-free 855-OH-CHILD (**855-642-4453**).

**Critical Incident Reporting**

Critical Incidents include, but are not limited to, abuse, neglect, exploitation, misappropriation greater than $500, accidental/unnatural death, self-harm or suicide with ER/Hospitlaization, Missing or Lost individual, or prescribed medication issues as per Ohio Administrative Code 5160-44-05.

Participating providers are required to report critical incidents to Humana Healthy Horizons in Ohio as soon as possible after the discovery of the incident, and no later than 24 hours after the critical incident occurred. Contact us at **877-856-5707** and be prepared to share the following details:

- facts relevant to the incident, such as a description of what happened;
- incident type;
- date of the incident;
- location of the incident;
- names and contact information of all persons involved; and
- any actions taken to ensure the health and welfare of the individual.

Humana Healthy Horizons in Ohio and participating providers shall immediately (not to exceed 24 hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members.

## Americans with Disabilities Act (ADA)

All Humana Healthy Horizons in Ohio-contracted healthcare providers must comply with the Americans with Disabilities Act (ADA), as well as all applicable state and/or federal laws, rules and regulations. More details are available in the Humana provider agreement under "Compliance with Regulatory Requirements."

Humana Healthy Horizons in Ohio develops individualized care plans that take into account members' special and unique needs. Healthcare providers with members who require interpretive services may contact their provider relations representative with questions.

Members who need interpretation services can call the number on the back of their member ID cards or visit Humana's website at **Humana.com/accessibility-resources**.

## Marketing Activities

Healthcare providers cannot orally or in writing compare benefits or provider networks among health plans, other than to confirm whether they participate in a health plan's network. If a provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.

Healthcare providers may announce a new affiliation with a health plan through general advertising (e.g., radio, television, websites). Providers may give their patients a list of health plans with which they contract.

## Member Rights and Responsibilities

**Member Rights**

Members of Humana Healthy Horizons in Ohio have the following rights:

- Receive all services Humana Healthy Horizons in Ohio is required to provide pursuant to the terms of their provider agreement with the Ohio Department of Medicaid (ODM).
- Be treated with respect and with due consideration for their dignity and privacy.
- Be ensured of confidential handling of information concerning their diagnoses, treatments, prognoses, and medical and social history.
- Be provided information about their health. Such information should also be made available to the individual legally authorized by the member to have such information or the person to be notified in the event of an emergency when concern for a member's health makes it inadvisable to give him/her such information.
- Be given the opportunity to participate in decisions involving their health care.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand, regardless of cost or benefit coverage.
- Maintain auditory and visual privacy during all health care examinations or treatment visits.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of their medical records, and to be able to request that their medical records be amended or corrected.
- Be afforded the opportunity to approve or refuse the release of information except when release is required by law.
- Be afforded the opportunity to refuse treatment or therapy. Members who refuse treatment or therapy will be counseled relative to the consequences of their decision and documentation will be entered into the medical record accordingly.
- Be afforded the opportunity to file grievances, appeals, or state hearings pursuant to the provisions of rule 5160-26-08.4 of the Administrative Code.
- Be provided written member information from Humana Healthy Horizons in Ohio:
  - At no cost to the member,
  - In the prevalent non-English languages of members in Humana Healthy Horizons in Ohio's service area, and
  - In alternative formats and in an appropriate manner that takes into consideration the special needs of members.
- Receive necessary oral interpretation and oral translation services at no cost.
- Receive necessary services of sign language assistance at no cost.
- Be informed of specific student practitioner roles and the right to refuse student care.
- Refuse to participate in experimental research.
- Formulate advance directives and to file any complaints concerning noncompliance with advance directives with the Ohio Department of Health.
- Change primary care providers (PCPs) no less often than monthly. Humana must mail written confirmation to the member of his or her new PCP selection prior to or on the effective date of the change.
- Appeal to or file directly with the United States Department of Health and Human Services Office of Civil Rights all complaints of discrimination on the basis of race, color, national origin, age or disability in the receipt of health services.
- Appeal to or file directly with the ODM office of civil rights all complaints of discrimination on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services in the receipt of health services.
- Be free to exercise their rights and to be assured that exercising their rights does not adversely affect the way Humana, Humana Healthy Horizons in Ohio's providers, or ODM treats the member.
- Be assured that Humana Healthy Horizons in Ohio must comply with all applicable federal and state laws and other laws regarding privacy and confidentiality.
- Choose his or her health professional to the extent possible and appropriate.
- For female members, to obtain direct access to a woman's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to a member's designated PCP if the PCP is not a woman's health specialist.
- Be provided a second opinion from a qualified health care professional that participates with Humana Healthy Horizons in Ohio. If such a qualified health care professional is not available within the network, then Humana Healthy Horizons in Ohio must arrange for a second opinion outside the network, at no cost to the member.
- Receive information on their Humana Healthy Horizons in Ohio plan, its services, practitioners and providers and member rights and responsibilities.

**Member Responsibilities**

Members of Humana Healthy Horizons in Ohio have the following responsibilities:

- Work with their PCP to protect and improve their health.
- Find out how the health plan coverage works.
- Listen to the PCP's advice and ask questions when in doubt.
- Call or go back to the PCP if they do not get better or ask to see another provider.
- Treat healthcare staff with the respect.
- Tell Humana Healthy Horizons in Ohio if they have problems with any healthcare staff by calling Member Services at **877-856-5702 (TTY: 711)**.
- Keep appointments and calling as soon as possible to cancel.
- Use the emergency department only for real emergencies.
- Call the PCP when medical care is needed, even if it is after-hours.
- Make recommendations to the Humana Healthy Horizons in Ohio member rights and responsibilities policy.

Members of Humana Healthy Horizons in Ohio must be sure to:

- Know their rights.
- Follow Humana Healthy Horizons in Ohio and ODM policies and procedures.
- Know about their service and treatment options.
- Take an active part in decisions about their personal health and care and lead a healthy lifestyle.
- Understand as much as they can about their health issues.
- Take part in reaching goals in agreement with the healthcare provider.
- Let Humana know if they are unhappy with us or one of our providers.
- Use only approved providers.
- Report suspected fraud, waste, or abuse.
- Keep scheduled doctor visits (e.g., be on time, and, if they have to cancel, call at least 24 hours in advance).
- Follow the advice and instructions for care in agreement with doctors and other healthcare providers.
- Always carry and show their member ID card when receiving services.
- Never let anyone use their member ID card.
- Let Humana Healthy Horizons in Ohio know of a name, address, or phone number change, or a change in the size of their family (e.g., birth, death, etc.).
- Call the assigned PCP after going to an urgent care center, a medical emergency, or receiving medical care outside of the Humana Healthy Horizons in Ohio service area.
- Let Humana Healthy Horizons in Ohio and ODM know if they have other health insurance coverage.
- Provide the information that Humana Healthy Horizons in Ohio and healthcare providers need to provide care.
- Notify Humana Healthy Horizons in Ohio immediately of any worker's compensation claim, a pending personal injury or medical malpractice lawsuit, or if when they've been in an auto accident.

Humana Healthy Horizons in Ohio advises members of changes to our member rights and responsibilities on our website at **Humana.com/HealthyOhio**.

# Provider Enrollment, Credentialing and Contracting

## Provider Enrollment (ODM Functions)

**General provider information/enrollment information**

Pursuant to 42 Code of Federal Regulations (CFR) 438.602, the Ohio Department of Medicaid (ODM) is required to screen, enroll, and revalidate all managed care organization (MCO) network providers. This provision does not require MCO network providers to render services to fee-for-service (FFS) beneficiaries.

There are many resources available on the Ohio Department of Medicaid website about the requirements to become a participating provider. Please visit **medicaid.ohio.gov/resources-for-providers/enrollment-and-support/provider-enrollment/provider-enrollment-lp** for several useful documents that answer relevant questions.

Organizational provider types will be required to pay a fee. The fee applies to organizational providers only; it does not apply to individual providers and practitioners or practitioner groups. The fee is a federal requirement described in 42 CFS 445.460 and in OAC 5160:1-17.8. The fee for 2023 is $688 per application and is not refundable. The fee will not be required if the enrolling organizational provider has paid the fee to either Medicare or another state Medicaid agency within the past five years. However, Ohio Medicaid will require that the enrolling organizational providers submit proof of payment with their application. (See OAC 5160:1-17.8 )

## Termination, suspension, or denial of ODM provider enrollment

For a list of termination, suspension and denial actions initiated by the state against a provider or applicant that allow for hearing rights please refer to Ohio Revised Code 5164.38.

For a list of termination, suspension and denial actions initiated by the state Medicaid agency against a provider or applicant that allow for reconsideration please refer to Ohio Administrative Code 5160-70-02.

## Loss of licensure

In accordance with Ohio Administrative Code 5160-1-17.8, a Medicaid provider agreement will be terminated when any license, permit, or certification that is required in the provider agreement or department rule has been denied, suspended, revoked, not renewed or is otherwise limited and the provider has been afforded the opportunity for a hearing in accordance with the hearing process established by the official, board, commission, department, division, bureau, or other agency of state or federal government.

## Enrollment and reinstatement after termination or denial

If a provider's Medicaid provider agreement is terminated or an applicant's application is denied, the applicant/provider should contact Ohio Medicaid via the Provider Enrollment Hotline (**800-686-1516**) to discuss the requirements to reapply. This process may include conversations with the ODM Compliance unit who will provide specific instruction on re-instatement requirements, if applicable.

## Provider maintenance

The Provider Network Management (PNM) module serves as the source of truth for provider data for ODM and the MCOs. As a result, data in the PNM is used in both the plan's provider directory and ODM provider directory. To ensure provider information remains current it is important for providers to keep their information up to date in the PNM.

Updating the PNM: When there is a change in a provider's information, please log in to the system, choose the provider you are editing, and click the appropriate button to begin an update. Self service functions include location changes, specialty changes, and key demographic (IE name, NPI etc.) changes. This information is sent to the MCOs on a daily basis for use in their individual directories. The provider must update their information in the PNM system first. The MCOs are required to direct providers back to the PNM if there are changes and cannot update their information unless it has already been updated in PNM.

**Important note:** Active **Ohio Medicaid provider number** submitted to MCO on provider roster must match exactly to OH Medicaid ID as reflected in ODM's Provider Network Management (PNM) system (formerly known as Medicaid Information Technology Information System (MITS))

**National Provider Identifier (NPI)** submitted to MCO on provider roster must match exactly to NPI as reflected in ODM Provider Network Management (PNM) system (formerly known as Medicaid Information Technology Information System (MITS))

## ODM provider call center

If you have questions or need assistance with your Ohio Medicaid enrollment, call the ODM Provider Hotline at **800-686-1516** through the interactive voice response (IVR) system. It provides 24 hour, 7 days a week access to information regarding provider information. Provider representatives are available via the IVR system weekdays from 8 a.m. to 4:30 p.m.

## Helpful information

**Medicaid Provider Resources**
**medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support**

**Federal guidelines for enrollment and screening (42 CFR 455 Subpart E)**
**law.cornell.edu/cfr/text/42/part-455/subpart-E**

**Ohio Revised Code**
**codes.ohio.gov/ohio-revised-code/chapter-5160**
**codes.ohio.gov/ohio-revised-code/chapter-3963**

**Ohio Administrative Code**
**codes.ohio.gov/ohio-administrative-code/5160**

## Provider Contracting (MCO Functions)

**Contracting process**

Our network resources webpage at **Humana.com/provider/medical-resources/join-Humana-network.com** includes information for providers interested in joining the Humana Healthy Horizons in Ohio network.

Humana Healthy Horizons in Ohio will contract with providers who are licensed and/or certified by the appropriate Ohio licensing body or standard-setting agency and are enrolled with ODM as a Qualified Medicaid Provider. If a provider is not active in ODM's provider network management system, Humana Healthy Horizons in Ohio must direct the provider to ODM's portal to submit an application for screening, enrollment, and credentialing prior to contracting.

Requests for Humana Healthy Horizons in Ohio medical and behavioral health network participation should be sent to:

- Email: **OhioNetworkSpecialist@humana.com**
- Call: **877-856-5707**, Monday through Friday, 7 a.m. to 8 p.m., Eastern time

A written response approving or denying participation must be sent to providers who submit a network participation request. The request is sent via US mail, fax or email, within 90 days of receipt of the request.

The following is a sample of Humana's Ohio Medicaid Provider Amendment. Upon publication of this Provider Manual the following amendment was the most recent version approved by ODM. Provider contracting documents are subject to revisions; to view the latest version(s) approved by ODM, please visit **apps.humana.com/marketing/documents.asp?file=4698382**.

Sample provider agreement: **apps.humana.com/marketing/documents.asp?file=4698226**

## Medicaid Addendum

Network provider contracts must include the appropriate ODM-approved Model Medicaid Addendum, which incorporates all applicable OAC rule requirements.

The ODM Medicaid Addendum supplements the Base Contract or Agreement between the managed care organization and provider and runs concurrently with the terms of the Base Contract or Agreement. The Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members. Attachment A is needed to identify the providers' capacity and service location. Attachment B is only required for hospital providers to identify services or religious/moral objections. Attachment C is only required when the contract between the managed care entity and the provider includes less specialties than the provider identified in the Provider Network Management (PNM) system. The most current Medicaid Addendum is posted on the ODM website here: **medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/mc-policy/managed-care-program-appendix/managed-care-program-addenda**.

The addendum must be completed along with the MCO provider contract.

## Termination, suspension or denial of contract

**Denial of Contract**

The decision to deny participation may be based on a variety of factors including, but not limited to, Ohio Medicaid program enrollment status, specialty coverage, network adequacy, geographic considerations and/or provider's cost efficiency.

Denials to Network Participation Requests written responses denying participation must include:

- The reason for the adverse decision declining participation;
- The provider's right to appeal the denial and request for additional documented information in support of the provider's view on the decision;
- Notification that after expiration of one year from the date of the final notification letter, provider may reapply to Humana for a reconsideration of network participation.

**Provider appeals process for denial of contract**

Providers may appeal an adverse decision declining participation. If a provider appeals an adverse decision from participation, the request from the provider must be submitted to Humana in writing as follows:

1) Submit their request to appeal any denial of participation in writing to the following address:
   **Humana Healthy Horizons in Ohio**
   485 Metro Place, South 5th Floor
   Dublin, OH 43017
2) Attach any additional documented information the physician is requesting that Humana review supporting provider's appeal;
3) Include the name and address of contact person for provider with request; and
4) Request for appeal must be dated and postmarked not more than 30 calendar days from the date of the adverse decision notification from Humana.
5) Provider must submit all documentation and supporting information they wish Humana to consider at least 1 day prior to the date of the scheduled meeting to consider the Provider's appeal.

On receipt of written request from a provider for an appeal, Humana will schedule a meeting to discuss the appeal. The provider will be sent a letter that contains notification of the date of the scheduled meeting and a due date for all information to be submitted. Once a decision is made on the appeal, a written response is sent to the provider indicating Humana's final decision.

**Suspension**

When ODM notifies Humana that a provider has been suspended, Humana Healthy Horizons in Ohio immediately suspends the provider, including all payments to the provider. Humana must continue to suspend the provider until it receives notice from the ODM to lift the suspension. When ODM notifies Humana that a provider is no longer suspended, Humana must lift the suspension and process any suspended claims.

**Termination**

Humana notifies providers of Participation Agreement (i.e. contract) termination or non-renewal according to the terms outlined in the Participation Agreement or, if

not specified, then no less than 90 calendar days prior to the effective termination date or as otherwise required by state or federal regulations or accreditation requirements.

Provider must provide Humana with notice according to the terms outlined in the Participation Agreement regarding any termination or non-renewal to allow Humana to comply with the member notification timeframes required by applicable state and/or federal law, accreditation standards and ODM contract requirements. The notification to Humana must be in writing and comply with the contractual requirements for notice to initiate the Participation Agreement termination.

## Out-of-state Providers/Non-contracted Providers

If there is an insufficient number or type of participating providers or facilities to provide a covered service to a member without unreasonable travel or delay, Humana Healthy Horizons in Ohio will use best efforts to ensure that member obtains the covered service from a provider or facility within reasonable proximity to the member. Single-case agreements (e.g. member-specific letter of agreement) will be executed with non-participating providers, including those out-of-state, to ensure in-network level of benefits, including an in-network level of cost-sharing.

## Plan Provider Call Center

The Humana Healthy Horizons in Ohio Provider Services center, **877-856-5707** is available Monday through Friday, 7 a.m. to 8 p.m. Eastern time, is an interactive voice recognition (IVR) line that assists providers with questions and requested information including contracting process and contracting status.

## Credentialing/Recredentialing Process

**ODM Credentialing Process**

Credentialing will be done by ODM for any provider.

- ODM is responsible for credentialing all Medicaid Managed Care providers. The credentialing and recredentialing processes are paired with enrollment and revalidation, respectively, in the Provider Network Management system. This process adheres to National Committee for Quality Assurance (NCQA) and CMS federal guidelines for both processes and the types of providers who are subject to the credentialing process.
- Please note, you are not able to render services to Medicaid members until you are fully screened, enrolled, and credentialed (if required) by Ohio Medicaid. For a complete list of provider types that require credentialing, please refer to Ohio Administrative Code (OAC) rule 5160-1-42.
- For individual providers, the general guidance is that licensed providers who can practice independently under state law are required to go through this process. Medical students, residents, fellows, and providers who practice strictly in an inpatient setting are exempt from credentialing. It is recommended that you begin the contracting process with each Managed Care Organization (MCO) you wish to participate with while you are enrolling and being credentialed at ODM, in order to be able to render services as of your effective date. While the credentialing process is being centralized at the state Medicaid level, you are still required to contract with the MCOs.
- When you submit your initial application to be an Ohio Medicaid provider, you can designate managed care organization interest in the PNM system. Once your application is submitted, demographic data for your provider is transmitted automatically to the MCOs so they can start contracting with you.

## Delegated Services, Policies and Procedures

**Scope**

The guidelines and responsibilities outlined in this appendix are applicable to all contracted Humana delegated entities (delegate). The policies in Humana Healthy Horizons in Ohio's Provider Manual for Physicians, Hospitals and Other Healthcare Providers (i.e. manual) also apply to delegated entities. ODM has to approve any delegation of Humana's responsibilities under the Next Generation Provider Agreement.

The information provided is designed primarily for the delegate's administrative staff responsible for the implementation or administration of certain functions that Humana has delegated to an entity.

**Oversight**

Although a health plan can delegate the authority to perform a function, it cannot delegate the responsibility or accountability for making sure that the function is performed in an appropriate and compliant manner. Since Humana Healthy Horizons in Ohio remains responsible for the performance and compliance of any function that is delegated, Humana Healthy Horizons in Ohio provides oversight of the delegate.

Oversight is the formal process through which Humana Healthy Horizons in Ohio performs auditing and monitoring of the delegate's:

- Ability to perform the delegated function(s) on an ongoing basis

- Compliance with accreditation organization standards, state and federal regulatory requirements and Humana/ policies and procedures, as well as their underlying contractual requirements pertaining to the provision of healthcare services
- Financial soundness (if delegated for claims adjudication and payment).

The delegation process begins with Humana Healthy Horizons in Ohio performing a pre-delegation audit prior to any function being delegated to a prospective entity, which includes evaluation of a prospective delegate's compliance and performance capacity. After approval and an executed delegation agreement, Humana Healthy Horizons in Ohio will perform an annual audit. The pre-delegation and annual audits will include a review and approval of the following applicable items of the prospective delegate:

- Policies and procedures
- Program descriptions and work plans
- Forms, tools and reports
- Sub-delegation agreements
- Audit of contracted sub-delegate's program, including policies, procedures and program documents
- Letters of accreditation
- Financial solvency (claims delegation only)
- File audit
- Federal/state exclusion screenings
- Offshore contracting

Humana Healthy Horizons in Ohio will continue to monitor all delegated entities through the collection of periodic reporting outlined within the delegation agreement. Humana Healthy Horizons in Ohio will provide the templates and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana Healthy Horizons in Ohio standards. All changes will be communicated to the delegate at such time.

**Corrective Action Plans**

Failure of the delegate to adequately perform any of the delegated functions in accordance with Humana Healthy Horizons in Ohio requirements, federal and state laws, rules and regulations, or accreditation organization standards may result in a written corrective action plan (CAP). The delegate will provide a written response describing how they will meet the requirements found to be noncompliant, including the expected remediation date of compliance.

Humana Healthy Horizons in Ohio will cooperate with the delegate or its subcontractors to correct any failure. Any failure by the delegate to comply with its contractual requirements or this manual, or any request by Humana Healthy Horizons in Ohio for the development of a CAP, may result, at Humana Healthy Horizons in Ohio's discretion, in the immediate suspension or revocation of all or any portion of the functions and activities delegated. This includes withholding a portion of the reimbursement or payment under the contract agreement.

**Humana Legal, Regulatory and Accreditation Requirements**

The delegate will comply with the following requirements:

- Submit all material change in the performance of delegated functions to Humana Healthy Horizons in Ohio for review and approval, prior to the effective date of the proposed changes.
- If required by state and/or federal law, rule or regulation, obtain and maintain, in good standing, a third-party administrator license/certificate and or a utilization review license or certification.
- Ensure that personnel who carry out the delegated services have appropriate training, licensure and/or certification.
- Adhere to Humana Healthy Horizons in Ohio's record retention policy for all delegated function documents, which is 10 years (identical to the CMS requirement).
- Agree to not have a more stringent preauthorization and notification list than Humana Healthy Horizons in Ohio's, which is posted on **Humana.com**.
- Follow Humana's Part B Step Therapy policy.
- Comply with requirements to issue member denial and approval letters in the member's preferred language if required by state laws, rules or regulations.

**Sub-delegation**

The delegate must have Humana Healthy Horizons in Ohio's prior written approval for any sub-delegation by the delegate of any functions and/or activities and notify Humana of changed or additional offshore locations or functions. Delegate must provide Humana with documentation of the pre-delegation audit that delegate performed of the subcontractor's compliance with the functions and/or activities to be delegated.

In addition, Humana Healthy Horizons in Ohio must notify CMS within 30 days of the contract signature date of any location outside of the United States or a U.S. territory that receives, processes, transfers, stores or accesses Medicare beneficiary protected health information in oral, written or electronic form.

**Please note:** Certain states may prohibit Medicaid protected health information from leaving the United States or U.S. territory.

If Humana Healthy Horizons in Ohio approves the sub-delegation, the delegate will provide Humana Healthy Horizons in Ohio documentation of a written sub-delegation agreement that:

- Is mutually agreed on.
- Describes the activities and responsibilities of the delegate and the sub-delegate.
- Requires at least semiannual reporting of the sub-delegate to the delegate.
- Describes the process by which the delegate evaluates the sub-delegate's performance.
- Describes the remedies available to the delegate if the sub-delegate does not fulfill its obligations, including revocation of the delegation agreement.
- Allows Humana Healthy Horizons in Ohio access to all records and documentation pertaining to monitoring and oversight of the delegated activities.
- Requires delegated functions be performed in accordance with Humana Healthy Horizons in Ohio and delegate's requirements, state and federal rules, laws and regulations and accreditation organization standards and is subject to the terms of the written agreement between Humana Healthy Horizons in Ohio and the delegate.
- Retains Humana Healthy Horizons in Ohio's right to perform evaluation and oversight of the subcontractor.

The delegate is responsible for providing adequate oversight of the subcontractor and any other downstream entities.

The delegate must provide Humana Healthy Horizons in Ohio with documentation of such oversight prior to delegation and annually thereafter. Humana Healthy Horizons in Ohio retains the right to perform additional evaluation and oversight of the subcontractor, if deemed necessary by Humana Healthy Horizons in Ohio. Furthermore, Humana Healthy Horizons in Ohio retains the right to modify, rescind or terminate, at any time, any one or all delegated activities, regardless of any sub-delegation that was previously approved.

A delegate agrees to monitor the subcontractor for federal and state government program exclusions on a monthly basis for Medicare and Medicaid providers and maintain such records for monitoring activities. If delegate finds that a provider, subcontractor or employee is excluded from any federal and/or state government program, they are removed from providing direct or indirect services for Humana Healthy Horizons in Ohio members immediately.

**Appeals and Grievances**

Humana Healthy Horizons in Ohio member appeals/grievances and expedited appeals processes are not delegated, including any appeal made by a physician/provider on behalf of the member, with the exception of clinical decision making when necessary. Humana maintains all member rights and responsibility functions except in certain special circumstances, as noted above. Therefore, the delegate will:

- Forward member appeals/grievances to Humana within one business day. Forward all expedited appeals immediately on notification/receipt.
- Telephone: **877-856-5702** Fax: **800-949-2961**
- When faxing, delegate will provide the following information: date and time of receipt, member information, summary of the appeal or grievance, all denial information, if applicable, and summary of any actions taken, if applicable.
- Promptly effectuate the appeal decision as rendered by Humana Healthy Horizons in Ohio and support any requests received from Humana Healthy Horizons in Ohio in an expedited manner.
- Delegate will handle all participating physician, provider, hospital and other healthcare professional provider claim payment and payment denial disputes. Humana Healthy Horizons in Ohio will handle all non-participating physician, practitioner, hospital and other healthcare professional provider claim payment and payment denial disputes or requests for reconsiderations.

**Utilization Management Delegation**

Delegation of utilization management (UM) is the process by which the delegated entity evaluates the necessity, appropriateness and efficiency of healthcare services to be provided to members. Generally, a review coordinator gathers information about the proposed hospitalization, service or procedure from the patient and/or provider, and then determines whether it meets established guidelines and criteria. Reviews can occur prospectively, concurrently (including urgent/emergent) and/or retrospectively.

**UM Activities and Responsibilities**

Delegates conduct the following functions regarding initial standard and expedited/urgent determinations:

- Perform preadmission review and authorization, including medical necessity determinations based on approved criteria, specific benefits and member eligibility.
- In full-risk arrangements, Humana Healthy Horizons in Ohio performs this function when review decisions by delegate are not timely, are contrary to medical necessity criteria and/or when Humana Healthy Horizons in Ohio must resolve a disagreement between delegate, providers and member. In some local health plans, Humana Healthy Horizons in Ohio may assume total responsibility for this function.
- For concurrent review activities relevant to inpatient and SNF stays, delegate should:
  - Provide on-site or telephone review for continued stay assessment using approved criteria.
  - Identify potential quality-of-care concerns, including hospital reportable incidents, including, but not

limited to, sentinel events and never events, and notification to the local health plan for review within 24 hours of identification or per contract. Humana Healthy Horizons in Ohio does not delegate quality-of-care determinations.
  - Provide continued stay determinations
  - Perform discharge planning and retrospective review activities.
- Perform, manage and monitor the referral process for outpatient/ambulatory care. Determine the appropriateness of each referral to specialists, therapists, etc., as it relates to medical necessity. Delegate is also responsible for conducting retrospective reviews for outpatient/ambulatory care.
- Notify member, facility and provider of decision on initial determination using Humana/state approved letter templates.
- For all determinations, maintain log and submit as required by regulatory and accreditation organization requirements. Humana retains the right to make the final decision regardless of contract type.
- Maintain documentation of pertinent clinical information gathered to support the decision.
- Maintain member denial files, including all supporting documentation; identify potential quality-of-care concerns and notify Humana Healthy Horizons in Ohio within 24 hours of identifying such cases. Humana Healthy Horizons in Ohio does not delegate quality-of-care determinations.
- Understand that denial files and all supporting documentation are Humana Healthy Horizons in Ohio's property. Should the contract between the delegate and Humana Healthy Horizons in Ohio be dissolved for any reason, the delegate is expected to make available to Humana Healthy Horizons in Ohio either the original or quality copies of all denial files for Humana Healthy Horizons in Ohio members.
- Perform UM activities for out-of-service areas and out-of-network providers as dictated by contract.
- Provide applicable UM reporting requirements outlined within the contract and related addenda or attachments. Humana Healthy Horizons in Ohio will provide the template and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana Healthy Horizons in Ohio standards. Any changes are communicated to the delegate at such time.

**Population Health Management Delegation**

Delegation of Population Health Management (PHM) must include the following:

**Complex Case Management (CCM):** CCM is the coordination of care and services provided to members who experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the healthcare system to facilitate appropriate delivery of care and services.

**Disease Management:** Disease management (DM) is a multidisciplinary, continuum-based approach to healthcare delivery that proactively identifies populations with, or at risk for, established medical conditions.

Delegate should provide applicable PHM reports as outlined within the contract and related addenda or attachments. Humana Healthy Horizons in Ohio provides the template and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana Healthy Horizons in Ohio standards. All changes are communicated to the delegate at such time.

**Claims Delegation**

Claims delegation is a formal process by which a health plan gives a participating provider (i.e. delegate) the authority to process claims on its behalf. Humana Healthy Horizons in Ohio's criterion for defining claims delegation is when the risk provider pays fee-for service claims. Capitation agreements in which the contractor pays downstream contractors via a capitation distribution formula do not fall under the definition of claims delegation.

Humana Healthy Horizons in Ohio retains the right and final authority to pay all claims for its members regardless of any delegation of such functions or activities to delegate. Amounts authorized for payment by Humana Healthy Horizons in Ohio of such claims may be charged against the delegate's funding. Refer to your provider agreement for funding arrangement details.

**Claims Performance Requirements:** All delegates performing claims processing functions must comply with all state and federal regulatory requirements.

In addition, delegates must conduct claims adjudication and processing in accordance with the member's plan and Humana Healthy Horizons in Ohio's policies and procedures. Delegate will need to meet, at a minimum, the following claims adjudication and processing requirements:

- Delegate must accurately process at least 95% of all delegated claims according to Humana requirements and in accordance with state and federal laws, rules and regulations and/or any regulatory or accrediting entity to whom Humana is subject.
- Delegate must process all claims in accordance with state and federal prompt pay requirements to which

Humana Healthy Horizons in Ohio is subject.

- Delegate must pay any and all interest amounts on claims in accordance with applicable state and federal requirements.
- Delegate must maintain an accuracy rate of 99% of total dollars paid, for any given calendar month.
- In the event the delegate is responsible for the processing and payment of claims for services rendered to any Humana Medicare Advantage or Medicaid members, delegate must comply with and meet the rules and requirements for the processing of Medicare Advantage or Medicaid claims established or implemented by CMS or the state.
- Delegate should use and maintain a claims processing system that meets current legal, professional and regulatory requirements.
- Delegate shall submit claim/encounter data in the format defined in the Process Integration Attachment.
- Delegation shall use Humana Healthy Horizons in Ohio's member letter templates for all member communications.
- Delegate should prints its name and logo on applicable written communications including letters or other documents related to adjudication or adjustment of member benefits and medical claims.
- Delegation should forward all nonparticipating reconsideration requests to Humana Healthy Horizons in Ohio on receipt.
  - Delegate should provide applicable claim reports as outlined within the contract and related addenda or attachments. Humana Healthy Horizons in Ohio will provide the template and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana Healthy Horizons in Ohio standards. Any changes are communicated to the delegate at such time.
- Delegate shall provide a financial guarantee, acceptable to Humana Healthy Horizons in Ohio, prior to implementation of any delegation of claims processing, such as a letter of credit, to ensure its continued financial solvency and ability to adjudicate and process claims. Delegate shall submit appropriate financial information upon request as proof of its continued financial solvency.
- Delegate shall retain and maintain legal, claims and encounter documents for the period of time and in the manner required by state and federal law or Humana Healthy Horizons in Ohio, including without limitation HIPAA and/or all requirements of regulatory or accreditation organization to which Humana Healthy Horizons in Ohio is subject, whether voluntarily or not.
- Delegate shall make available as requested by Humana Healthy Horizons in Ohio all original files, records and documentation pertaining to Humana Healthy Horizons in Ohio enrollees, or copies thereof on the termination of the performance of delegated functions and/or the expiration, nonrenewal or termination of the agreement, regardless of the cause.

**Continuous Quality Improvement Delegation**

All delegates are expected to function within a framework of continuous quality improvement and cooperate with Humana Healthy Horizons in Ohio's quality improvement program. Additionally, some managed behavioral health organizations (MBHOs), or other entities, may be delegated for a formal quality improvement function. This includes the following:

- Select quantifiable standards, goals and benchmarks for each monitoring activity.
- Collect, analyze and discuss data for each monitoring activity. At a minimum, the delegate's Quality Improvement committee should discuss the data. Humana Healthy Horizons in Ohio should approve data collection methods.
- Plan and implement corrective actions to improve performance.
- Re-measure to determine success of corrective action interventions.
- Cite quantifiable care and service improvements related to the tracking and trending of Humana Healthy Horizons in Ohio member

# Covered Services

## General Services

It is the responsibility of the Humana Healthy Horizons in Ohio to notify ODM as soon as they become aware of medical situations where ODM medical policy isn't clearly defined. ODM recognizes that these medical situations may occur from time to time and will address on a case-by-case basis.

More detailed information on Medicaid Policy for services and benefits may be found in the corresponding provider manual for each service and Provider type. These manuals are available electronically on the ODM website at **medicaid.ohio.gov**.

Humana Healthy Horizons in Ohio is required to provide its Ohio Medicaid members "Medically Necessary" care, at the very least, at current limitations for the services listed below. Medically necessary services are those services utilized in the Ohio Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Ohio statutes and regulations, the state plan,

and other Ohio policy and procedures. While appropriate and necessary care must be provided, Humana Healthy Horizons in Ohio is not bound by the current variety of service settings.

## List of Covered Services - Covered Services/ Core Benefits

- Acupuncture
- Ambulance and ambulette services
- Behavioral health services
- Blood glucometers and blood glucose test strips
- Chiropractic services
- Dental services
- Developmental therapy
- Durable medical equipment (DME) and medical supplies
- Emergency/post-stabilization services
- Family planning services and supplies
- Free-standing birth center services
- Home health and private-duty nursing services
- Hospice care
- Immunizations
- Inpatient hospital services
- Nursing facility stays for aged, blind and disabled (ABD) and Modified Adjusted Gross Income (MAGI) members
- Laboratory and X-ray services
- Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services
- Occupational therapy
- Outpatient hospital services
- Physician-administered drugs and services provided by pharmacist providers
- Pharmacy/prescription drugs
- Physical therapy
- Podiatry services
- Preventive services
- Respite services for Supplemental Security Income (SSI) members younger than 21 with long-term care or behavioral health needs
- Screening and counseling for obesity
- Screening, diagnosis, and treatment services for children younger than 21 through Healthchek, Ohio's Periodic Screening, Diagnosis, and Treatment (EPSDT) program.
- Services for members with a primary diagnosis of autism spectrum disorder (ASD)
- Services provided by rural health clinics (RHCs) and federally qualified health centers (FQHCs)
- Speech therapy
- Substance use disorder treatment services
- Telemedicine services
- Vision care services, including eyeglasses
- Additional services

**Behavioral Health and Substance-use Services**

Behavioral health and substance-use services are covered services for Humana Healthy Horizons in Ohio members. Humana Healthy Horizons in Ohio recognizes that behavioral health and physical health function as a part of the whole person, and one can affect the other. Therefore, we use a holistic approach to address behavioral health and substance use.

Humana Healthy Horizons in Ohio provides a comprehensive range of behavioral health services, including:

- Outpatient coverage for medication management, therapy services (individual, group and family therapy) and case management offered through key providers
- A broad range of hospital-based services for both behavioral health and substance dependence disorders, including
  - Intensive outpatient
  - Partial hospitalization
  - Crisis stabilization
  - Long- and short-term inpatient stays based on medical necessity

**Access to community-based resources**

Providers, members or other responsible parties can contact Humana Healthy Horizons in Ohio at **877-856-5707** to verify available behavioral health and substance-use benefits and to seek a referral or direction for obtaining behavioral health and substance-use services.

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

**Screening and Evaluation**

Humana Healthy Horizons in Ohio requires PCPs 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. PCPs may provide clinically appropriate behavioral health services within the scope of their practice. When assessing members for behavioral health services, Humana Healthy Horizons in Ohio and its providers must use the most current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. Humana Healthy Horizons in Ohio may require use of other diagnostic and assessment instrument/outcome measures in addition to the most current version of DSM. Providers should document DSM diagnosis and assessment/outcome information in the member's medical record.

Humana Healthy Horizons in Ohio provides training to network PCPs on how to screen and identify behavioral health disorders, Humana Healthy Horizons in Ohio's behavioral health services referral process and on clinical coordination requirements for such services. Humana Healthy Horizons in Ohio also includes coordination and quality of care training, education on the OhioRISE program for multi-system youth, and new models of behavioral health interventions.

## List of Covered Services - Value-Added Benefits (VAB)

Humana Healthy Horizons in Ohio offers members extra benefits, tools, and services, at no cost to the member, that are not otherwise covered or that exceed limits outlined in the Ohio Plan and the Ohio Medicaid Fee Schedules. These added benefits are in excess of the amount, duration and scope of those services listed above.

In instances where an added benefit also is a Medicaid covered service, Humana Healthy Horizons in Ohio administers the benefit in accordance with all applicable service standards pursuant to our contract, the Ohio Medicaid State Plan and all Medicaid coverage and limitations handbooks.

Humana Healthy Horizons in Ohio Medicaid members have specific enhanced benefits:

| Value-added benefit | Details and limitations |
|---|---|
| Cell Phone Services | Free cell phone through the Federal Lifeline Program, per household. Members who are under 18 will need a parent or guardian to sign up.<br><br>This benefit covers per lifetime: 1 phone, 1 charger, 1 set of instructions, 350 minutes per month, 4.5 GB of data per month, unlimited text messages per month, training for you and your caregiver at the first case manager orientation visit. This benefit also includes unlimited calls to Humana member Services for health plan assistance and 911 for emergencies even if you run out of minutes. You must make at least 1 phone call or send 1 text message every month to keep your benefit.<br><br>You may also qualify for enhanced benefits through the Affordable Connectivity Program (ACP) that provides unlimited minutes, 5 GB hotspot and 25 GB of data. You can opt into this benefit by contacting SafeLink at **877-631-2550** or online at **safelink.com**<br><br>Benefits are subject to change by the FCC under the Lifeline program. |
| Childcare Assistance | Up to $50 per quarter, up to four times per year, for reimbursement for childcare expenses for caretakers who are seeking employment. Member must participate in some sort of Workforce program to be eligible. |
| Dental services - Adult | Members 21 and older to have one additional cleaning per year with an in-network provider. |
| Employment physical exam | One employment physical exam per year for members 18 and older. |
| GEDWorks | General Educational Development (GED) test preparation assistance for members 16 and older, including a bilingual advisor, access to guidance and study materials, and unlimited use of practice tests. Test preparation assistance is provided virtually to allow maximum flexibility for member. Also includes test pass guarantee to provide member multiple attempts at passing the test.<br><br>**Please note:** For those members 16 or 17 years old, a consent form must be signed by either the parent, guardian or court official and submitted. Additionally, the member must be officially withdrawn from school. |

| Value-added benefit | Details and limitations |
|---|---|
| Member Assistance Program (MAP) | **Childcare support includes:**<br>• Support to identify child care options, including child care centers, family day care homes, nanny agencies, babysitter search tools, back-up/on-demand child care<br>• Special needs support information: support groups, advocates, child care for special needs children, socialization groups, special needs services (i.e. ABA therapy)<br>**Counseling and caregiving support includes:**<br>• Behavioral health counseling and support for caregivers of a Humana member (up to three sessions.) Authorization is required.<br>**Legal and financial support includes:**<br>• Support for do-it-yourself document preparation<br>- Wills/living wills<br>• Consultations with attorneys, mediators, CPAs and financial professionals<br>• Under the legal/financial piece of the MAP program, members have access to free 30 minute consultations with attorneys/financial consultants, depending on the issue for which they seek support |
| Member Assistance Program (MAP) – continued | **Legal and financial support includes – continued:**<br>• Members also can receive support for budget preparation through this service, and if members need to retain an attorney, the program (and pricing) includes a 25% discount for the legal services. |
| Portable crib | Member must consent to participate in the HumanaBeginnings® care manager program, complete the comprehensive assessment, and complete one additional follow-up call within 56 days, or 8 weeks, of enrollment or identification of a pregnancy indicator<br>One crib, per pregnancy, per child |
| Post-discharge meals | Up to 10 home-delivered meals following discharge from an inpatient or residential facility, limit 40 meals per year (up to four discharges) |
| Social services support | Up to $500 allowance for members 18 and older toward assistance with utility, bills, eviction diversion, etc. Once per lifetime. At the Care Management staff discretion |

| Value-added benefit | Details and limitations |
|---|---|
| Transportation | All members receive 30 one-way (15 round) trips that are less than 30 miles per calendar year. (Case manager approval not required)<br><br>A. Trips falling under this category include:<br>• Doctor, dental, and vision appointments<br>• Grocery store food banks<br>• WIC appointments<br>• SNAP appointments<br>• CDJFS redetermination appointments<br>• Social support (support group, wellness classes)<br>• Redetermination appointment<br>• Job interviews and GED classes<br>• Maternity childbirth classes / baby showers<br><br>Additional transportation may be available for members enrolled in Humana case management programs<br><br>Unlimited chronic conditions requiring in-person treatment (care manager not necessary):<br>• Dialysis<br>• Radiation chemotherapy<br>• Diabetes Management<br>• Hospital Discharge<br>• Urgent Care<br>• Organ Transplant<br>• Wound Care<br>• Prenatal Trips<br>• Postpartum Trips up to 12 months to Doctors Appointments |
| Vision services - Adult | For members 21-59, one eye exam per year and up to $200 allowance for one set of glasses (frames and lenses) or contacts, not both during the plan year.<br>Member pays any cost more than $200. |

## List of Covered Services – Incentive Programs

**Go365© for Humana Healthy Horizons™**

Go365 for Humana Healthy Horizons is a wellness program that offers members the opportunity to earn rewards for taking healthy actions. Most of the rewards are earned by Humana Healthy Horizons in Ohio's receipt of the provider's claim for services rendered.

Humana Healthy Horizons in Ohio recommends that all providers submit their claims on behalf of a member by Feb. 15, 2024. This allows the member time to redeem their reward. A member will have 90 days from one plan year to another, assuming they remain continuously enrolled, to redeem their rewards.

Go365 is available to all members who meet the requirements of the program. Rewards are not used to direct the member to select a certain provider. Rewards are non-transferrable to other managed care plans or other programs.

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

Members can qualify to earn rewards by completing one or more of the following healthy activities:

| Healthy activity | Reward |
|---|---|
| Health Risk Assessment (HRA) | $25 in rewards for members who complete their Health Risk Assessment HRA within 90 days of enrollment with Humana Healthy Horizons in Ohio (one per lifetime) |
| Breast cancer screening | $50 in rewards for female members 40 and older who obtain a mammogram (once per year) |
| Cervical cancer screening | $50 in rewards for female members 21 and older who receive a PAP smear (once per year) |
| Colorectal cancer screening | $25 in rewards for members 45 and older who receive a colorectal cancer screening as recommended by their primary care provider (once per year) |

| Healthy activity | Reward |
|---|---|
| Diabetic retinal exam | $25 in rewards for diabetic members 21 and older who complete a retinal eye exam (once per year) |
| Diabetic screening | Up to $50 In rewards for diabetic members 21 and older who complete annual HbA1c and kidney screenings with their PCP. Members will receive $25 in rewards for completing an HbA1c screening and $25 in rewards for completing a kidney screening (once per year) |
| Flu vaccine | $25 in rewards for members 13 and older who receive an annual flu shot from their provider, pharmacy or self-reporting if they have received a vaccine from another source (once per year) |
| COVID-19 vaccine | $25 in rewards for members 12 and older who upload a picture/file of their completed COVID-19 vaccine card, one per year. Members vaccinated prior to enrollment in Humana Healthy Horizons in Ohio may upload vaccination card within 90 days of enrollment to receive the reward. New members that were not vaccinated prior to enrollment in Humana Healthy Horizons in Ohio, have 90 days from completion of vaccination and upload the vaccination card to receive the reward. |
| Tobacco cessation program | For all members 12 and older, up to eight health coaching/cessation support calls within 12 months from enrollment date. For members 18 and older, nicotine replacement therapy on request.<br><br>This program will have two opportunities where members can earn rewards. Member must opt into Go365 mobile app to be eligible to receive reward.<br><br>$25 in rewards for members who complete two calls within the first 45 days of enrollment in the coaching program, one per year.<br><br>$25 in rewards for members who complete six additional wellness coaching calls (eight total) within 12 months of the first coaching session, one per year. |
| Weight management program | Enrollment in weight management program, completion of a well-being check-up and form with their primary care provider (PCP), completion of six total wellness coaching calls within 12 months of enrollment date or return of the PCP form.<br><br>This program will have two opportunities where members 12 and older can earn rewards. Member must opt into Go365 mobile app to be eligible to receive reward.<br><br>$10 in rewards: Enrollment in the weight management program<br>- Completion of wellbeing checkup with primary care provider<br>- Submission of PCP form<br><br>$20 in rewards: Completion of the program<br>- Six wellness coaching calls within 12 months of the first coaching session |
| Postpartum visit | $50 in rewards for all postpartum females who complete one postpartum visit within 7 to 84 days after delivery (one per pregnancy) |
| Prenatal visit | Up to $105 in rewards for pregnant females who complete prenatal visits. Members are eligible for $15 in rewards per visit, with a seven visit limit. |
| Well-child visits (0-15 months) | Up to $90 in rewards. Members who complete a well-child visit are eligible for $15 in rewards per visit with a six visit limit. |
| Well-child visits (16-30 months) | Up to $30 in rewards. Members who complete a well-child visit are eligible for $15 per visit with a two visit limit. |

| Healthy activity | Reward |
|---|---|
| Well-child visits (3 to 20 years) | $50 in rewards for members who complete one annual wellness visit (once per year) |
| Wellness visit | $25 in rewards for members 21 and older who complete one annual wellness visit (once per year) |

## Pharmacy

Humana Healthy Horizons in Ohio provides coverage of medically necessary medications, prescribed by Medicaid certified licensed prescribers in the state. Humana Healthy Horizons in Ohio adheres to state and federal regulations on medication coverage for our members. Humana Healthy Horizons in Ohio and other health plans in the state are required to use a single pharmacy benefit manager (SPBM), Gainwell Technologies. For more information about Ohio's SPBM, please refer to the **SPBM section** in this manual.

**Drug Coverage**

Gainwell Technologies utilizes a uniform Preferred Drug List (PDL) and utilization management, which are developed by ODM. ODM notifies providers of changes to the **PDL**.

Gainwell is responsible for providing pharmacy benefits, including prior authorizations for all Ohio Medicaid individuals.

**Copay**

Medicines on the PDL have a $0 copay when filled at a network pharmacy.

**Medication Therapy Management (MTM)**

Humana Healthy Horizons in Ohio offers a Medication Therapy Management (MTM) program that helps ensure patients achieve the best possible outcomes from their medications. The patient-centered MTM program promotes collaboration between the pharmacist, patient and prescriber to optimize safe and effective medication use. The goal of this program is to optimize therapeutic outcomes by focusing on safety, effectiveness, lower-cost alternatives and adherence.

Prescribers with questions about the program may call **888-210-8622 (TTY: 711)**, Monday through Friday, from 8 a.m. to 7 p.m., Eastern time.

**Over-the-counter (OTC) Health and Wellness**

Humana Healthy Horizon in Ohio members have an expanded pharmacy benefit, which provides a $30 per month allowance to spend on OTC health and wellness items. UPS or the U.S. Postal Service send OTCs and products within 10 to 14 working days after the order is received. There is no charge to the member for shipping. You can find a full list and order form of the OTC health and wellness items that the member can get in the mail on the OTC order at **Humana.com**.

If you have questions about this mail-order service, please call the Humana Pharmacy at **855-211-8370 (TTY: 711)**

**Coordinated Services Program**

The coordinated services program (CSP) is designed for individuals enrolled in Humana Healthy Horizons in Ohio who need help managing their use of prescription medications. It is intended to limit overuse of benefits and reduce unnecessary costs to Medicaid while providing an appropriate level of care for the member. Members who meet the program criteria are locked into one specific pharmacy location initially for a total of two years. Members receive written notification from Humana Healthy Horizons in Ohio, along with the designated lock-in pharmacy's information and the member's right to appeal the plan's decision. Members are notified as to whether the request for the change is approved or denied.

Excluded from enrollment in CSP are members who:

- Have a current diagnosis of cancer and receive chemotherapy or radiation treatment
- Resides in a long-term care facility
- Receives hospice services
- Is enrolled in both the Medicaid and Medicare programs

## Requirements Regarding the Submission and Processing of Requests for Specialist Referrals

Humana Healthy Horizons in Ohio members may see any participating network provider, including specialists and inpatient hospitals. Humana Healthy Horizons in Ohio does not require referrals from PCPs to see participating specialists; however, prior authorization must be obtained for nonparticipating providers. Members may self-refer to any participating provider. PCPs do not need to arrange or approve these services for members, as long as applicable benefit limits have not been exhausted.

**Second Opinions for Nonparticipating Providers**

A second opinion is not required for surgery or other medical services. However, providers or members may request a second opinion at no cost. The following criteria should be used when selecting a provider for a second opinion.

The provider:

- Must participate in the Humana Healthy Horizons in Ohio network. If not, prior authorization must be obtained.
- Must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- Must be in an appropriate specialty area.

Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

Humana Healthy Horizons in Ohio arranges for out-of-network care if it is unable to provide necessary covered services, a second opinion or if a network healthcare provider is unavailable. In these situations, Humana Healthy Horizons in Ohio coordinate payment with the out-of-network provider to confirm that any cost to the member is not greater than it would be if the service were provided in-network.

## Transportation Vendor Contact Information

**Non-emergency Medical Transportation**

Members can obtain transportation through Humana Healthy Horizons' Non-Emergent Medical Transportation vendor Access2Care by calling **855-739-5986**. Members may also contact the Medicaid Transportation Coordinator at the local county department of job and family services (CDJFS). The main phone number for each CDJFS is included in a list available at **jfs.ohio.gov**; select County Directory.

## Transportation Policies/coverage

Transportation is covered when the member must travel 30 miles or more from the member's home to receive a medically necessary Medicaid-covered service provided by Humana Healthy Horizons in Ohio and pharmacy services provided by the Single Pharmacy Benefit Manager (SPBM). The plan also covers non-ambulatory transportation.

## Transportation Services for Members Enrolled in OhioRISE

The MCO must arrange and provide transportation for members who are enrolled with the OhioRISE plan in a manner that ensures that children, youth, and their families served by the OhioRISE plan do not face transportation barriers to receive services regardless of Medicaid payer. The MCO is responsible for arranging transportation in cases where transportation of families, caregivers, and sibling (other minor residents of the home) is needed to facilitate the treatment needs of the member.

## Emergency and Post-stabilization Care Services

In accordance with Section 1852(d)(2) of the Act and 42 C.F.R. §§ 438.114(b), 422.113(c), and 438.114(d), Humana Healthy Horizons in Ohio must cover and pay for emergency and post-stabilization care services. This includes ensuring the determination of the attending emergency physician, or the provider actually treating the member, of when the member is sufficiently stabilized for transfer or discharge is binding on the plan and State for coverage and payment of emergency and post-stabilization care services.

1.6.18.1 Emergency Services- In accordance with Section 1932(b)(2) of the Act and 42 C.F.R. §§ 438.114(c)(1)-(2) and 438.114(c)(1)(ii)(A) - (B) Humana Healthy Horizons in Ohio shall:

- Pay non-participating providers for emergency services no more than the amount that would have been paid if the service had been provided under the Ohio's fee-for-service Medicaid program.
- Cover and pay for emergency services regardless of whether the provider that furnished the services has a contract with the plan.
- Not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- Not deny payment for treatment obtained when a representative of the plan instructs the member to seek emergency services.

- Provide coverage and payment for services until the attending emergency physician, or the provider actually treating the member, determines that the member is sufficiently stabilized for transfer or discharge.

In accordance with 42 C.F.R. §§ 438.114(d)(1)-(2), Humana Healthy Horizons in Ohio shall not:

- Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
- Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's PCMH or the plan, or applicable state entity of the member's screening and treatment within 10 calendar days of presentation for emergency services.
- Hold a member who had an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the condition.

Post-stabilization services- In accordance with 42 C.F.R. §§ 438.114(e), 422.113(c)(2)(i) - (ii), and 422.113(c)(2)(iii)(A) - (C), Humana Healthy Horizons in Ohio shall cover post-stabilization care services that are:

- Obtained within or outside the plan network that are:
  - Pre-approved by a plan provider or representative.
  - Not pre-approved by a plan provider or representative, but administered to maintain the member's stabilized condition within one hour of a request to the plan for pre-approval of further post-stabilization care services.
- Administered to maintain, improve, or resolve the member's stabilized condition without preauthorization, and regardless of whether the member obtains the services within the Humana Healthy Horizons in Ohio network when the plan:
  - Did not respond to a request for pre-approval within one hour.
  - Could not be contacted.
  - Representative and the treating physician could not reach agreement concerning the member's care and a plan physician was not available for consultation.

In accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c)(2)(iv), Humana Healthy Horizons in Ohio shall limit charges to member for post-stabilization care services to an amount no greater than what Humana Healthy Horizons in Ohio would charge the member if he or she obtained the services through Humana Healthy Horizons in Ohio.

In accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c)(3)(i) - (iv), Humana Healthy Horizons in Ohio's financial responsibility for post-stabilization care services if not pre-approved ends when:

- A Humana Healthy Horizons in Ohio contacted physician with privileges at the treating hospital assumes responsibility for the member's care.
- A Humana Healthy Horizons in Ohio contracted physician assumes responsibility for the member's care through transfer.
- A Humana Healthy Horizons in Ohio representative and the treating physician reach an agreement concerning the member's care.
- The member is discharged.

## Early and Periodic Screening and Diagnosis and Treatment (EPSDT) and Healthchek

Healthchek is Ohio's EPSDT program. EPSDT is a federally mandated program developed for Medicaid recipients from birth through the end of their 21st birth month. All Humana Healthy Horizons in Ohio members within this age range should receive age-recommended EPSDT preventive exams, health screens and EPSDT special services needed to address health issues as soon as identified or suspected. Providers must utilize ODM-developed standard screening tools The screening tools and more information is available at ODM's Healthchek program website at **medicaid.ohio.gov/wps/portal/gov/medicaid/families-and-individuals/citizen-programs-and-initiatives/healthchek1/healthchek**

EPSDT benefits are available at no cost to members.
On identifying a member as pregnant, Humana Healthy Horizons of Ohio will deliver a pregnancy related services form as designated by ODM.

**EPSDT Preventive Services**

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

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

Covered services EPSDT preventive exam components include:

- Comprehensive health and development history
- Comprehensive unclothed physical examination
- Laboratory tests, including (where indicated) blood-lead level screening/testing, anemia test using hematocrit or hemoglobin determinations, sickle-cell test, complete

urinalysis, testing for sexually transmitted diseases, tuberculin test and pelvic examination
- Developmental screening/surveillance, including autism screening
- Sensory screenings and referrals for vision and hearing
- Nutritional assessment, including body mass index (BMI) and blood pressure
- Dental screenings and referrals to a dentist, as indicated (dental referrals are recommended during a child's first year of life and are required at two years and older)
- Psychological/behavioral assessments, substance-use assessments and depression screenings
- Assessment of immunization status and administration of required vaccines
- Health education and anticipatory guidance (e.g., age-appropriate development, healthy lifestyles, accident and disease prevention, at-risk and risk behaviors and safety)
- Referral for further evaluation, diagnosis and treatment
- Routine screening for postpartum depression should be integrated into well-child visits at one, two, five and six months

**EPSDT Special Services**

Under the EPSDT benefit, Medicaid provides comprehensive coverage for any service described in section 1905(a) of the Social Security Act. EPSDT special services include coverage for other medically necessary healthcare, evaluation, diagnostic services, preventive services, rehabilitative services and treatment or other measures not covered under Ohio Medicaid, including:

- Special services included in the EPSDT benefit may be preventive, diagnostic or rehabilitative treatment or services that are medically necessary to correct or ameliorate the individual's physical, developmental or behavioral condition.
- Medically necessary services are available regardless whether those services are covered by Ohio Medicaid.
- Medical necessity is determined on a case-by-case basis.
- EPSDT special services that are subject to medical necessity often require prior authorization.
- Consideration by the payer source must be given to the child's long-term needs, not only immediate needs and consider all aspects such as physical, developmental, behavioral, etc.

**EPSDT Exam Frequency**

The Humana Healthy Horizons in Ohio EPSDT Periodicity Schedule is updated frequently to reflect current recommendations of the American Academy of Pediatrics (AAP) and Bright Futures. To view updates to the schedule, please visit **aap.org**.

**Infancy:**

| | | |
|---|---|---|
| Younger than 1 month | 2 months | 4 months |
| 6 months | 9 months | 12 months |

**Early childhood:**

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

**Middle childhood:**

| | | |
|---|---|---|
| 5 years | 6 years | 7 years |
| 8 years | 9 years | 10 years |

**Adolescence and young adults:**

| | | |
|---|---|---|
| 11 years | 12 years | 13 years |
| 14 years | 15 years | 16 years |
| 17 years | 18 years | 19 years |
| 20 years | 21 years (through the end of the member's 21st birth month) | |

**Child Blood-lead Screenings**

Federal regulation requires that all children receive a blood test for lead at:

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

This is a required part of the EPSDT exam provided at these ages. Additionally, Ohio law requires all healthcare providers to administer blood lead tests to children at age 1 and 2, or up to age 6 if no previous test has been completed based on the following criteria: the child is on Medicaid, lives in a high-risk ZIP code, or has certain other risk factors. More information on child lead poisoning and high-risk Zip codes can be found at the Ohio Department of Health (odh.ohio.gov) **Child Lead Poisoning Program** website.

**Immunizations**

Immunizations are an important part of preventive care for children and should be administered during well-child/EPSDT exams as needed. Humana Healthy Horizons in Ohio endorses the same childhood immunization schedule recommended by the CDC and approved by the Advisory Committee on Immunization Practices (ACIP), the

**Bright Futures/American Academy of Pediatrics (AAP) Medical Periodicity Schedule** and the American Academy of Family Physicians (AAFP). This schedule is updated annually and current updates can be found on the AAP website at **aap.org**.

**Annual HealthChek Education**
Humana Healthy Horizons in Ohio provides Healthchek education to all network contracted providers on an annual basis that includes:

- Required components of a Healthchek exam pursuant to OAC rule 5160-01-14
- A list of the intervals at which members younger than 21 should receive screening examinations, as indicated by the most recent version of the document "Recommendations for Preventive Pediatric Health Care" published by Bright Futures/American Academy of Pediatrics
- A list of common billing codes and procedures related to the Healthchek services (e.g. immunizations, well-child exams, laboratory tests, and screenings) is available at **downloads.aap.org/AAP/PDF/Coding%20Preventive%20Care.pdf**

Additional information on Healthchek can be found at the Ohio Department of Medicaid **Healthchek Program** website.

**Optimization of pregnancy outcomes**
Learn about the Ohio Perinatal Quality Collaborative (OPQC) Progesterone Project and how to notify us when one of our members in your panel is pregnant.

Ohio Perinatal Quality Collaborative (OPQC) Progesterone Project

**The Ohio Perinatal Quality Collaborative (OPQC)**
Progesterone Project's goal is to decrease premature births in Ohio before 32 weeks by 10%, by:

- Identifying women with increased risk early in pregnancy
- Starting treatment with progesterone

Learn more about the Prematurity Prevention (Progesterone) Project at **opqc.squarespace.com/prematurity-prevention**

**Pregnancy Risk Assessment Communication**
The Pregnancy Risk Assessment Communication (PRAF) is Ohio Medicaid's preferred method for providers to notify the state and us of an individual's pregnancy. You can submit this information via a paper or online form. The form is called PRAF 2.0 online.
The PRAF 2.0:

- Is ODM's preferred notification of pregnancy
- Is the only pregnancy notification that automatically
  - Updates Medicaid eligibility, which helps to
    - Prevent loss of Medicaid coverage during pregnancy
    - Prevent payment delays
  - Notifies us of a pregnancy
  - Notifies the home health agency of the need for progesterone
  - Assesses for additional patient needs
- Results in the generation of a progesterone prescription that can be printed and faxes or taken to a pharmacy

Submit a completed PRAF 2.0 by visiting **progesterone.nurtureohio.com/login**

Find the paper PRAF by visiting **medicaid.ohio.gov/static/Resources/Publications/Forms/ODM10207fillx.pdf**

Physicians can find instructions for completing the paper PRAF at **medicaid.ohio.gov/static/Resources/Publications/Forms/ODM10207i.pdf**

## Benefit Manager

**DentaQuest**
Humana Healthy Horizons in Ohio contracted with DentaQuest to provide members with routine and value-added dental benefits.

For more information, you can call Ohio Provider Relations at **855-398-8411**.

**EyeMed**
Humana Healthy Horizons in Ohio contracted with EyeMed to provide members with routine and value-added vision benefits

For more information, you can call the Provider Call Center at **888-581-3648** or providers can log into EyeMed's Provider Portal (called inFocus) at **www.eyemedinfocus.com/**

**Tivity**
Plan members receive covered chiropractic and acupuncture management services through participating providers through WholeHealth Networks, Inc., a Tivity company. For more information, providers can call Tivity at **866-430-8647** or visit **WholeHealthPro.com**.

## Non-covered Services

Humana Healthy Horizons in Ohio will not pay for services or supplies received that are not covered by Medicaid:

- Services that are experimental in nature and are not performed in accordance with standards of medical practice.
- Services that are related to forensic studies.
- Autopsy services.
- Services for the treatment of infertility.
- Abortion services that do not meet the criteria for

coverage in accordance with Ohio Administrative Code rule 5160-17-01.
- Services pertaining to a pregnancy that is a result of a contract for surrogacy services.
- Assisted suicide and other measures taken actively with the specific intent of causing or hastening death; and
- Services that do not meet the criteria for coverage set forth in any other rule in Ohio Administrative Code Agency 5160.

The following services not covered by the Ohio Medicaid program:
- Services or supplies not medically necessary
- Treatment of obesity unless medically necessary
- Voluntary sterilization if younger than 21 or legally incapable of consenting to the procedure
- Reversal of voluntary sterilization procedures
- Plastic or cosmetic surgery not medically necessary (These services could be deemed medically necessary if medical complications or conditions, in addition to the physical imperfection, are present)
- Sexual or marriage counseling
- Biofeedback services
- Paternity testing
- Services determined by another third-party payer as not medically necessary
- Drugs not covered by the Ohio Medicaid pharmacy program
- Medical services if the service was caused by a provider-preventable condition
- Non-emergency services or supplies provided by out-of-network providers, unless the member followed the instructions in the MCP member handbook for seeking coverage of such services, or unless otherwise directed by ODM.

## Telehealth Services

The following responsibilities are required by ODM when your office provides telehealth services:
- Telehealth services must be delivered in accordance with all state and federal laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any HIPAA related directives from the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) issued during COVID-19 national emergency and 42 C.F.R. part 2 (Jan. 1, 2020).
- The practitioner site is responsible for maintaining documentation in accordance with HIPAA requirements for the health-care service delivered through the use of telehealth and to document the specific telehealth modality used.
- Services must be delivered in accordance with rules set forth by their respective licensing board and accepted standards of clinical practice.
- If telehealth services are rendered to a member for a period longer than 12 consecutive months, providers are expected to conduct at least one in-person annual visit or refer the member to a practitioner or their usual source of clinical care that is not an emergency department for an in-person annual visit.
- Telehealth does not replace provider choice and/or member preference for in-person service delivery.
- Telehealth will not be considered as an alternative to meeting provider network access requirements.

## Transplant Services

The Humana Transplant Services team helps members and their physicians navigate the complex world of transplant care and make informed decisions by:
- Helping members choose a transplant program
- Assigning a dedicated transplant care manager for authorization and care management services
- Dedicating specially trained staff to handle claims quickly and efficiently

To reach Humana's team of transplant care managers, call **866-421-5663**, email **transplant@humana.com** or reach out by fax at **502-508-9300**. Care managers are available to assist you Monday through Friday, 8 a.m. to 5 p.m. local time.

Messages left after hours will receive a response the next business day.

## Grievance, Appeal and State Hearing Procedures and Time Frames

This section outlines the member's appeal rights and grievance process. For provider claim disputes regarding any provider inquiries, complaints, or requests for reconsiderations ranging from general questions about a claim to a provider disagreeing with a claim denial, please see **Claim Dispute Process section** of this manual.

**Grievances (Complaints)**

Members may file a grievance when they are dissatisfied with Humana Healthy Horizons in Ohio or a provider. Providers may assist members in filing a grievance when the member provides written consent. Grievances can be filed verbally or in writing:
- Calling Member Services at **877-856-5702**
- Filling out the standardized form
- Writing a letter that includes the following information:
  - Member name
  - Member identification number from the front of the
  - Humana Healthy Horizons in Ohio ID card

- Member address and phone number in the letter
- Explanation of issue

Submit written grievances:
Mail the form or letter to:
**Humana Healthy Horizons in Ohio**
Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546

Fax the form or letter to: **800-949-2961**

Humana Healthy Horizons in Ohio will acknowledge claims related and non-claims related grievances within three business days of the day we receive the grievance.

Following Humana Healthy Horizons in Ohio's review, a decision letter is sent within:
- Two days for access grievances
- 30 days for non-claim related grievances
- 60 days for claims related grievances

**Negative actions are not taken against a member who files a grievance or a provider that supports a member's grievance or files a grievance on behalf of a member with written consent.**

**Appeals**
If the member isn't satisfied with a decision or action Humana Healthy Horizons in Ohio takes an appeal can be filed by the member or their authorized representative. Appeals must be filed within 60 calendar days from the date of receipt of the Notice of Action (NOA), from us. Appeals can be filed by:
- Calling Member Services at **877-856-5702**
- Filling out the standardized appeal form
- Writing a letter that includes the following information:
  - Member name
  - Member identification number from the front of the
  - Humana Healthy Horizons in Ohio ID card
  - Member address and phone number in the letter
  - Any information that will help explain the appeal

Mail the form or letter to:
**Humana Healthy Horizons in Ohio**
Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546

Fax the form or letter to **800-949-2961**

Humana Healthy Horizons in Ohio will acknowledge your request within three business days of the day we receive the appeal.

If we extend the timeframe for the appeal we make reasonable efforts to provide a prompt oral notice of the delay. Humana Healthy Horizons in Ohio also sends written notice, within two calendar days, of the reason for the decision to extend the timeframe. We also inform the member of the right to file a grievance if there is disagreement with that decision.

After we complete the review of the appeal, we send a letter within fifteen days for standard appeals, advising of our decision

The member or someone that the member choses can:
- Review all of the information used to make the decision
- Provide more information throughout the appeal review process
- Examine the member's case file before and during the appeals process
  - This includes medical, clinical records, other documents and records, and all new or additional evidence considered, relied upon, or generated in connection with the appeal
  - This information shall be provided, on request, free of charge and sufficiently in advance of the resolution time frame

**If the member or appointed representative feel waiting for the 15-day timeframe to resolve an appeal could seriously harm** the member's health, they can request that we expedite the appeal. To expedite your appeal, it must meet the following criteria:
- A delay could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

We make decisions on expedited appeals within 72 hours or as fast as needed based on the member's health.
Negative actions will not be taken against:
- A member who files an appeal
- A provider that supports an member's appeal or files an appeal or expedited appeal on behalf of an member with written consent

Humana Healthy Horizons in Ohio will determine within one business day of the appeal request whether the expedite criteria is met. We will make reasonable efforts to provide a prompt oral notice as well as written notice of the reason for the decision to extend the time frame. We also inform the member of the right to file a grievance if there is disagreement with that decision.

**State Fair Hearings**
Member or their appointed representative also have the right to ask for a state fair hearing from the Ohio Department of Job and Family Services (ODJFS) Bureau of State Hearings or local County Department of Job and Family Services (CDJFS) after Humana Healthy Horizons in Ohio completes its appeal process. Requests must be made

within 90 days from the date on Humana Healthy Horizons in Ohio's appeal decision letter.

To request a state fair hearing:

- Call: Call the ODJFS Consumer Access Line at **866-635-3748**. Follow the instructions for State Hearings.
- Write:
  ODJFS Bureau of State Hearings
  P.O. Box 182825
  Columbus, Ohio 43218-2825
- Email: **bsh@jfs.ohio.gov**. In the subject, put "**State Hearing Request**."
- Fax: **614-728-9574**

Members that request a state fair hearing and want their Humana Healthy Horizons in Ohio benefits to continue, must file a request with Humana Healthy Horizons in Ohio within 15 days from the date the Notice of Action (NOA) is mailed.

Members with an urgent health condition can ask for an expedited hearing. If the hearing finds that Humana Healthy Horizons in Ohio's decision was correct, the member may have to pay the cost of the services provided for the benefits that were continued during the Medicaid State Fair Hearing.

**Continuation of Benefits**

For some adverse benefit determinations, member may request to continue services during the appeal and Medicaid Fair Hearing process. Services that can be continued must be those that the member already receives, including services that are being reduced or terminated.

Humana Healthy Horizons in Ohio continues services if you request an appeal within 15 days from our notice of adverse benefit determination letter, or before the date we advised they would be reduced or terminated, whichever is later. Member benefits continue until one of the following occurs:

- Until the original authorization period for services has ended
- 15 days after we mail the appeal decision
- The member withdraws the appeal
- Following a Medicaid Fair Hearing, the administrative law judge issues a decision that is not in the member's favor

If the appeal was denied and a request for a Medicaid Fair Hearing with continuation of services is received within 15 days of the date on the appeal resolution letter, the services will continue during the Medicaid Fair Hearing. Please see the Member Grievances, Appeals and State Fair Hearing Requests section of this manual.

However, if we decide that we agree with our first decision to deny your service, the member may be required to pay for these services.

# Utilization Management

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

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

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

## Services that Require Prior Authorization

Physicians or other healthcare providers should review the Ohio Medicaid Prior Authorization List" online at **Humana.com/PAL**.

## Prior Authorization Submission – Process and Format

Healthcare providers must submit all prior authorization requests, including physician-administered drug requests and associated attachments, through Availity Essentials via one of the following methods:

- Practice management system: Prior authorization submissions sent from a provider's practice management system
- Direct entry into Availity Essentials

For both of the above methods, select the following payor descriptions from the dropdown menu in Availity Essentials:

- Humana (medical)
- Humana Behavioral Health

Providers should review the Ohio Medicaid "Prior Authorization List" online at **Humana.com/PAL**.

Humana Healthy Horizons in Ohio does not require authorizations for Home Health Assessments.

Humana Healthy Horizons in Ohio allows providers to submit authorization requests for unplanned and/or emergency inpatient admissions the next business day and the Plan utilization review staff will review within the appropriate timeframes for decision making.

**UM Review**

- All decisions are based on eligibility, coverage and medical necessity criteria.
- Humana Healthy Horizons in Ohio uses ODM-developed medical necessity criteria and, where it does not exist, we use MCG™, American Society of Addiction Medicine (ASAM), and Humana Medical Coverage policies, as appropriate, based on OAC rules and member condition.
- As Humana Healthy Horizons in Ohio, applies coverage policies and medical necessity criteria, we will consider individual member needs and an assessment of the local delivery system

**Behavioral Health Services**

- Humana Healthy Horizons in Ohio does not require prior authorization for certain behavioral health services including Children and Adolescents Needs and Strengths (CANS) assessments and up to 72 hours of Mobile Response Stabilization Services (MRSS) (except in accordance with OAC rule 5160-27.13).
- Humana Healthy Horizons in Ohio requires prior authorization for admissions to Inpatient Psychiatric facilities, including Institutions for Mental Disease (IMD).

Please Note: Authorization disclosure for IMD admissions: Authorizations decisions are based on medical necessity criteria and clinical information provided at time of request. Authorizations are not a guarantee of payment.

Billed services are based on medical necessity, appropriate setting, billing/coding, total days paid for current month and eligibility at the time service was rendered.

Humana follows contractual agreements, state and federal regulations regarding IMD reimbursement for mental health and substance use disorder.

If you have any questions please contact our provider service line and/or claims/billing for assistance.

**Second Opinions**

- Humana Healthy Horizons in Ohio allows members to obtain a second medical opinion at no cost to the member.

**Out of Network Services**

- Humana Healthy Horizons in Ohio authorizes out-of-network care, based on medical necessity, when a network provider is not available to provide members with medically necessary covered services in a timely manner.
- Authorization requests must be submitted to **Availity Essentials** for members to receive out-of-network services.
- If the out-of-network provider is not an active provider in ODM's provider network management system, Humana Healthy Horizons in Ohio will verify the provider's licensure, conduct federal database checks and execute a single-case agreement. The out-of-network provider is required to submit an application via the ODM portal for screening, enrollment and credentialing. If an out-of-network provider is not willing to become an active ODM provider, the single case agreement is terminated.

**Value Added Benefits**

Additional value added benefits are available to Humana Healthy Horizons in Ohio's members without prior authorization. A list of these benefits is available to providers on the provider website or by using the following link: **Humana.com/HealthyOH**

## Time Frames for Responding to Standard and Expedited PA Requests (Medical and Behavioral Health)

**Standard**

Notice of decision as expeditiously as the member's health condition requires, but no later than 10 calendar days following receipt of the request for service.

**Concurrent determination**

Notice of decision as expeditiously as the member's health condition requires, but no later than three calendar days from the date of request

**Expedited/Urgent/IP Behavioral Health determination**
When a provider indicates, or Humana Healthy Horizons in Ohio determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, Humana Healthy Horizons in Ohio complete an expedited authorization as expeditiously as the member's health condition requires but no later than 48 hours after receipt. Please specify if you believe the request should be expedited.

## Provider Appeal Procedures

**Peer-to-peer Consultations**
Providers may request a peer-to-peer consultation when the MCO denies a prior authorization request. The peer-to-peer consultations will be conducted amongst health care professionals who have clinical expertise in treating the member's condition, with the equivalent or higher credentials as the requesting/ordering provider. The peer-to-peer consultation must clearly identify what documentation the provider must provide to obtain approval of the specific item, procedure, or service; or a more appropriate course of action based upon accepted clinical guidelines.

If you would like to request a peer-to-peer discussion on a determination with a Humana physician reviewer, please send an email to the **p2prequest@humana.com** or fax your request to **877-701-6524** or leave a voicemail at **877-207-0153**.

The Peer-to-Peer request must be made within five business days of the determination.

**Provider Appeals**
Providers may request a provider appeal if the MCO denies a prior authorization request in accordance with ORC 5160.34. The provider appeal is separate from the peer-to-peer or member appeal processes. Provider appeals will be responded to within forty-eight hours for urgent care services and within ten calendar days for all other matters.

If a Provider appeal is not fully resolved, the resolution will include next steps if a provider disagrees and include the opportunity for external review if the claim denial was due to medical necessity.

**Retrospective Determination**
Notice of decision within 30 calendar days of receipt of request.

**External Medical Review**
External Medical Review (EMR) –The review process conducted by an independent, external medical review entity that is initiated by a provider who disagrees with a managed care organizations (MCO's) decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity.

In the Next Generation Medicaid managed care program, the EMR will be conducted by Permedion.
This vendor has a contract with ODM to perform the EMR.

To request an EMR, providers must first appeal the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity using the MCO's internal provider appeal or claim dispute resolution process. Failure to exhaust the MCO's internal appeals or claim dispute resolution process will result in the provider's inability to request an EMR.

EMR is only available to providers for services delivered to members enrolled in Medicaid managed care and/or OhioRISE. The EMR process is not currently available in the MyCare Ohio and Single Pharmacy Benefit Manager (SPBM) programs.

An EMR can be requested by a provider as a result of:
- An MCO's service authorization denial, limitation, reduction, suspension, or termination (includes pre-service, concurrent, or retrospective authorization requests) based on medical necessity; or
- An MCO's claim payment denial, limitation, reduction, suspension, or termination based on medical necessity.
- An MCO does not issue its response to the provider's internal appeal of Humana Healthy Horizons in Ohio's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity within the required timeframes specified in ORC 5160.34(B)(12) for services authorizations or within 15 business days for provider claim disputes.

Denials, limitations, reductions, suspensions, or terminations based on lack of medical necessity include, but are not limited to decisions made by the plan where:
- Clinical documentation or medical record review is required in making the decision to deny (includes preservice, concurrent, and retrospective reviews).
- Clinical judgement or medical decision making (i.e., referred to a licensed practitioner for review) is involved.
- A clinical standard or medical necessity requirement (e.g., InterQual®, MCG®, ASAM, or OAC 5160-1- 01, including EPSDT criteria, and/or the MCO's clinical coverage or utilization management policy or policies) is not met.

MCOs are required to notify providers of their option to request an EMR as part of any denial notification.

**Requesting EMR**
The request for an EMR must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals or provider claim dispute process has

been exhausted. The external medical review is available at no cost to you.

Providers must complete the "Ohio Medicaid MCE External Review Request" form located at **www.hmspermedion.com** (select Contract Information and Ohio Medicaid) and submit to Permedion together with the required supporting documentation including:

- Copies of all adverse decision letters from MCO (initial and appeal)
- All medical records, statements (or letters) from treating health care providers, or other information that provider wants considered in reviewing case.

Providers must upload the request form and all supporting documentation to Permedion's provider portal located at **https://ecenter.hmsy.com/** (new users will send their documentation through secured email at **IMR@gainwelltechnologies.com** to establish portal access).

Note: When requesting an EMR, providers may submit new or other relevant documentation as part of the EMR request.

If Humana Healthy Horizons in Ohio determines the provider's EMR request is not eligible for an EMR and the provider disagrees, ODM or its designee will determine if an EMR is appropriate.

The EMR process does not interfere with the provider's right to request a peer-to-peer review, or a member's right to request an appeal or state hearing, or the timeliness of appeal and/or state hearing resolutions.

Once the provider has submitted the EMR request, they do not need to take further action.

**The EMR Review**

After the EMR request has been submitted, Permedion will share any documentation from the provider with Humana Healthy Horizons in Ohio. Following its review of this information Humana Healthy Horizons in Ohio may reverse its denial, in part or in whole. If Humana Healthy Horizons in Ohio reverses any part of its decision the provider will receive a written decision within one business day for expedited prior authorization requests and 5 business days for standard prior authorization requests and notify the EMR entity. If Humana Healthy Horizons in Ohio decides to reverse its decision in part, the remaining will continue as an EMR.

Permedion has 30 calendar days for a standard request and three business days for an expedited request to perform its review and issue a decision.

- If the decision reverses Humana Healthy Horizons in Ohio's coverage decision in part or in whole, that decision is final and binding on Humana Healthy Horizons in Ohio.
- If the decision agrees with Humana Healthy Horizons in Ohio's decision to deny, limit, reduce, suspend, or terminate a service, that decision is final.

For reversed service authorization decisions, Humana Healthy Horizons in Ohio must authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when Humana Healthy Horizons in Ohio receives the EMR decision.

For reversed decisions associated solely with provider payment (i.e., the service was already provided to the member), Humana Healthy Horizons in Ohio must pay for the disputed services within the timeframes established for claims payment in Appendix L of the Provider Agreement.

For more information about the EMR, please contact Permedion at **800-473-0802**, and select Option 2.

## Criteria

Humana Healthy Horizons in Ohio currently uses the following criteria to make medical necessity determinations of inpatient acute, behavioral health, rehabilitation and skilled nursing facility admissions:

- Ohio State regulations
- Milliman Care Guidelines (MCG)
- American Society of Addiction Medicine (ASAM) criteria, which are nationally recognized, evidence-based clinical UM guidelines
- Humana coverage policies

These guidelines are intended to allow Humana Healthy Horizons in Ohio to provide all members with care that is consistent with national quality standards and evidence-based guidelines. These guidelines are not intended as a replacement for a physician's medical expertise; they are to provide guidance to our physician providers related to medically appropriate care and treatment.

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

## Access to Staff

Providers may contact the utilization management staff with any UM questions.

**Medical health inquiries:** Call **877-856-5707** or email **OHMCDUM@humana.com**

**Behavioral health inquiries:** Call **877-856-5707** or email **OHMCDUMBH@humana.com**

Please keep the following in mind when contacting UM staff:

- Staff are available Monday through Friday, 8 a.m. to 5 p.m. Eastern time.
- Staff can receive inbound communication regarding UM issues after normal business hours.
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff are available to respond to email inquiries regarding UM issues.
- Staff are accessible to answer questions about the UM process.

In the best interest of our members and to promote positive healthcare outcomes, Humana Healthy Horizons in Ohio supports and encourages continuity of care and coordination of care between medical providers as well as between behavioral health providers.

Our members' health is always our No. 1 priority. Physician reviewers from Humana Healthy Horizons in Ohio are available to discuss individual cases with attending physicians on request.

Clinical criteria and clinical rationale or criteria used in making UM determinations are available on request by contacting our utilization management department.

## Continuity of Care for New Members

The MCO must allow a new member to receive services from network and out of network providers in the following circumstances:

- If the MCO confirms that the Group VIII-Expansion member is currently receiving care in a nursing facility on the effective date of enrollment with the MCO;
- If the member is pregnant and in the 3rd trimester of pregnancy
- If a member's practitioner is terminated from the Plan's network

**Group VIII-Expansion**

If the Plan confirms that the Group VIII-Expansion member is currently receiving care in a nursing facility on the effective date of enrollment with the Plan will cover the nursing facility care at the same facility until a medical necessity review is completed and, if applicable, a transition to an alternative location has been documented in the member's person-centered care plan.

**Pregnant Members**

If the Plan is aware of a pregnant member's enrollment, the Plan will identify the member's maternal risk and facilitate connection to services and supports in accordance with ODM's Guidance for Managed Care Organizations for the Provision of Enhanced Maternal Care Services guidance; and

The Plan must allow the pregnant member to continue with an out-of-network provider if the member is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital.

**Provider Termination**

If a practitioner's contract is discontinued, the Plan allows affected members continued access to the practitioner, as follows:

Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.

Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.

## Transition of Care Prior Authorizations

If the member has a prior authorization approved prior to the member's transition, the MCO must honor the prior authorization through the expiration of the authorization, regardless of whether the authorized or treating provider is in or out-of-network with the MCO.

The MCO may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service. The MCO must render an authorization decision pursuant to OAC rule 5160-26-03.1.

The MCO may assist the member to access services through a network provider when any of the following occur:

The member's condition stabilizes and the MCO can ensure no interruption to services;

The member chooses to change the member's current provider to a network provider; or

If there are quality concerns identified with the previously authorized provider.

The MCO must cover scheduled inpatient or outpatient surgeries approved and/or pre-certified pursuant to OAC rule 5160-2-40. Surgical procedures also include follow-up care as appropriate.

The MCO must cover organ, bone marrow, or hematopoietic stem cell transplant pursuant to OAC rule

5160-2-65 and as described in Appendix B, Coverage and Services, of this Agreement.

# Claims Information

## Process and Requirements for the Submission of Claims

Providers may submit claims, prior authorizations, and associated attachments through **Availity Essentials**.

**ODM Provider Network Management System Direct Data Entry**

- Providers may submit eligibility inquiries through the Provider Network Management (PNM) system
- Link to PNM **Provider Network Management (PNM) system**

**Electronic Data Interchange (EDI) submission of provider claims**

- Providers may submit claims, eligibility inquiries, claim status inquiries and associated attachments using Electronic Data Interchange (EDI) by being a trading partner (TP) authorized by ODM or by contracting with an ODM authorized TP.
- Link to ODM TP website **medicaid.ohio.gov/Provider/Billing/TradingPartners**

All payable claims, via electronic data interchange (EDI), must be submitted through the provider's EDI which must be an ODM fiscal intermediary/EDI as an established trading partner. Healthcare providers must submit manual claims and associated attachments through the **Availity Essentials portal**.

Humana's payer ID is 61103 for fee-for-service claims.

Please note: Humana's traditional payer ID for fee-for-services claims (61101) cannot be used to submit Humana Healthy Horizons in Ohio claims. Humana rejects all claims submitted in this manner.

*Paper claim submissions are prohibited.*

**Claim Submissions**

Claims must be submitted within 365 days from the date of service or from discharge. Corrected claims must be submitted within 365 from the date of service or 180 days from the date Medicare or the other insurance plan paid the claim.

All claims must include the following information:

- Patient address
- Insured's ID number: Be sure to provide the complete member ID for the patient
- Patient's birth date: Always include the member's date of birth so we can identify the correct member.
- Place of service: Use standard CMS location codes
- International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) diagnosis code(s)
- HIPAA-compliant Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code(s) and modifiers when modifiers are applicable
- Units, where applicable (anesthesia claims require number of minutes)
- Date of service: Please include dates for each individual service rendered; date ranges are not accepted, even though some claim forms contain from/to formats. Please enter each date individually.
- Prior authorization number, when applicable: A number is needed to match the claim to the corresponding prior authorization information. This is only needed if the service provided required a prior authorization.
- National Provider Identifier (NPI): Please refer to the Location of Provider NPI, TIN and member ID number section
- Federal Tax ID number or physician Social Security number: Every provider practice (e.g., legal business entity) has a different Tax ID number
- Billing and rendering taxonomy codes that match the ODM Master Provider List (MPL)
- Billing and rendering addresses that match the ODM MPL
- Signature of physician or supplier: The provider's complete name should be included. If we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

We do not pay claims with incomplete, incorrect or unclear information.

**Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Wrap-around Payments**

The following are Humana Healthy Horizons in Ohio's Medicaid provider numbers for use when submitting documents for wrap-around payments.

Line of Business – Region:

- Medicaid –Aged, Blind or Disabled (ABD)
  - Humana's Medicaid ID number: 0461038
- Medicaid –Covered Families and Children (CFC)
  - Humana's Medicaid ID number: 0462285

## Timely Filing Requirements

Providers will have 365 days to timely file a claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) rule 5160-1-19.

Providers have 365 days from the date of service or from discharge to submit a claim. If the claim is submitted after the applicable timely filing term, the claim will be denied for timely filing.

If a member has Medicare and Humana Healthy Horizons in Ohio is secondary, the provider may submit for secondary payment within 180 days from Medicare adjudication date.

If a member has other insurance and Humana Healthy Horizons in Ohio is secondary, it is recommended that the provider submit for secondary payment within 180 days from the other insurance payment date.

## Claims Status

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

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

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

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

By agreement, Humana Healthy Horizons in Ohio will adhere to the following guidelines and will be responsible for:

- Paying 90% of all submitted clean claims within 21 calendar days of the date of receipt
- Paying 99% of all submitted clean claims within 60 calendar days of the date of receipt
- Paying 100% of all submitted clean claims within 90 calendar days of the date of receipt

## Monitoring Claims; Explanation of Benefits (EOB)

In accordance with 42 CFR 455.20, Humana Healthy Horizons in Ohio will verify with members whether services billed by providers were received.
Humana Healthy Horizons in Ohio will mail an EOB every six months to members that received health care services within that timeframe. The EOB mailing complies with all state and federal regulations regarding release of personal health information, outlines the recent medical services identified as provided to the member and request that the member report any discrepancies to the MCO.

## Payment in Full Information

State requirements and federal regulations prohibit providers from billing Humana Healthy Horizons in Ohio members for medically necessary covered services except under very limited circumstances. Members cannot be billed and will be held harmless for services that are administratively denied. The only exception is if a Humana Healthy Horizons in Ohio member agrees in advance, in writing, to pay for a non-Medicaid covered service. This agreement must be completed prior to providing the service and the member must sign and date the agreement acknowledging member financial responsibility.

Providers who knowingly and willfully bill a member for a Medicaid-covered service are guilty of a felony and on conviction are fined, imprisoned or both, as defined in the Social Security Act. Providers should call Provider Services at **877-856-5707** for guidance before billing members for services.

## Member Copayments

Humana Healthy Horizons in Ohio does not require member copayments.

## Process and Requirements for Appeal of Denied Claims

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

**Please note:** Failure to include ICD-10 codes on submitted claims will result in claim denial.

## Provider Claim Dispute Resolution Process

Providers claim disputes are any provider inquiries, complaints, appeals, or requests for reconsideration ranging from general questions about a claim to a provider disagreeing with a claim denial. Providers may file a claim dispute within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later. Providers may submit claim disputes verbally or in writing, including through the provider portal.

Participating providers may contest the amount of payment, denial of the payment, or nonpayment of a claim within a period of eighteen (18) months following the date such claim was paid, denied or partially denied by Humana.

Claim disputes can come in through multiple channels, including:

Humana's provider portal: Complete Claims Status application on **Availity.com**

Verbally by calling Provider Services **877-856-5707**
or by mail
**Humana Healthy Horizons in Ohio**
Provider Claims Dispute
P.O. Box 14601
Lexington, KY 40512-4601

Humana may reject a provider's claim dispute submission if the provider's claim dispute request is incomplete, not submitted within the time frame specified and does not meet all of the requirements as specified above.

Humana Healthy Horizons in Ohio will resolve and provide written notice to the provider the claim dispute within 15 business days of receipt of the dispute. Within five business days of receipt of a dispute, Healthy Horizon in Ohio will notify the provider (verbally or in writing) that the dispute was received.

If additional time to resolve a dispute is needed past 15 business days, then Health Horizon of Ohio will provide a status update to the provider every five business days, beginning on the 15th business day until the dispute is resolved.

Humana Healthy Horizons in Ohio Reprocess and pay disputed claims, when the resolution determines they were paid/denied incorrectly, within 30 calendar days of the written notice of the resolution, unless a system fix is needed then additional time is allotted.

This provider dispute system will be utilized as the sole remedy to dispute the denial of payment of a claim or, in the case of a contracted, in-network provider, to dispute Humana Healthy Horizons in Ohio's policies, procedures, rates, contract disputes or any aspect of Humana Healthy Horizons in Ohio's administrative functions. Providers not otherwise acting in the capacity of an authorized

representative of a Medicaid Managed Care Member do not have appeal rights with the Department.

For claim payment inquiries or complaints, please contact Humana Healthy Horizons in Ohio at **877-856-5707** or your provider contracting representative.

**External Medical Review**
After exhausting Humana Healthy Horizons in Ohio's provider claims dispute resolution process, a provider may request an external medical review (EMR) if the claim payment denial, limitation, reduction, suspension, or termination was based on medical necessity. For more information on EMR, please see the Utilization Management section of this manual.

## Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA)

**EFT/ERA Enrollment through Humana Healthy Horizons in Ohio**
Get paid faster and reduce administrative paperwork with EFT and ERA. Provider can enroll for EFR and EFT through ODM's state portal.

## Submitting Electronic Transactions

**Provider Portal**
Humana Healthy Horizons in Ohio partners with Availity to allow providers to reference member and claim data for multiple payers using one login. Availity provides the following benefits:

- Eligibility and benefits
- Remittance advice

To learn more, call **800-282-4548** or visit **Availity.com**. For information regarding electronic claim submission, contact your local Provider Agreement representative or visit **Humana.com/providers** and choose "**Claims Resources**" then "Electronic Claims & Encounter Submissions" or **Availity.com**.

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

To submit claims electronically, providers must work with an electronic claim clearinghouse.

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

- 61103 for encounter claims

**Please note:** Humana's traditional payer ID for fee-for-services claims (61101) cannot be used to submit Humana Healthy Horizons in Ohio claims.

Humana will reject any claims submitted in this manner, as well as any claims entered directly into Humana's

Availity Provider portal, if the claims are for Ohio Medicaid members.

Humana Healthy Horizons in Ohio currently accepts electronic claims from Ohio providers through the following clearinghouses:

| | | |
|---|---|---|
| Availity | **Availity.com** | **800-282-4548** |
| Tizetto | **Trizetto.com** | **800-556-2231** |
| McKesson | **Mckesson.com** | **800-782-1334** |
| Change Healthcare | **Changehealthcare.com** | **800-792-5256** |
| SSI Group | **Thessigroup.com** | **800-820-4774** |

Please contact the clearinghouse of your choice to begin electronic claim submission.

**5010 transactions**

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

The following transactions are covered under the 5010 requirement:

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

**Importance of Encounter Submissions in Medicaid**

Encounters identify members who have received services:

- Decreases the need for medical record review during Healthcare Effectiveness Data and Information Set (HEDIS) audits
- Critical to future implementation of Medicaid risk adjustments
- Helps identify members receiving preventive screenings and decreases members listed in gaps-in-care (GAP) reports

Encounters data submissions helps establish data quality standards and requirements for Ohio's Medicaid Managed Care program and evaluates the member's access to quality services. This data is reviewed to help determine the performance measures, utilization reviews, care coordination and care management and determining incentives.

**Procedure and Diagnosis Codes**

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

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM), available from the U.S. Government Printing Office by calling **202-512-1800**, or faxing **202-512-2250**, and from other vendors
- Current Procedural Terminology (CPT), available at **Ama-assn.org/practice-management/cpt**
- HealthCare Common Procedure Coding system (HCPCS), available at **Cms.hhs.gov/default.asp**
- National Drug Codes (NDC), available at **FDA.gov**

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

**Unlisted CPT/HCPCS Codes**

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

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

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

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

Your NPI and Tax ID are required on all claims, in addition to your provider taxonomy and specialty type codes (e.g., Federally Qualified Health Center, Rural Health Center and/or Primary Care Center) using the required claim type format (X12 837 Format) for the services rendered.

Effective Nov. 25, 2019, ODM implemented a policy under Administrative Code 5160-1-17 requiring all providers to obtain a NPI and keep it on file with ODM. In accordance with Administrative Code rule 5160-1-17, all providers with an available taxonomy are required to have a NPI on file with ODM. This includes certified providers of waiver services through the Ohio Department of Developmental Disabilities (DODD), the Ohio Department of Aging (ODA), and providers of state plan services through the Ohio Department of Medicaid (ODM).

**Location of Provider NPI, TIN and Member ID number**

Humana Healthy Horizons in Ohio accepts electronic claims

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

On 5010 (837P) professional claims:

The provider NPI should be in the following location:
- Medicaid: 2010AA Loop – Billing provider name
- 2010AA Loop – Billing provider name
- Identification code qualifier – NM108 = XX
- Identification code – NM109 = billing provider NPI
- 2310B Loop – rendering provider name
- Identification code qualifier – NM108 = XX
- Identification Code – NM109 = rendering provider NPI

The billing provider TIN must be submitted as the secondary provider identifier using a REF segment, which is either the employer identification number for organizations (EIN) or the Social Security number (SSN) for individuals:
- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN
- The billing provider taxonomy code in box 33b

On 5010 (837I) Institutional Claims:

The billing provider NPI should be in the following location:
- 2010AA Loop – Billing provider name
- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = billing provider NPI

The billing provider Tax ID Number (TIN) must be submitted as the secondary provider identifier using a REF segment, which is either the EIN for organizations or the SSN for individuals:
- Reference identification qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference identification – REF02 = Billing provider TIN or SSN
- The billing taxonomy code goes in box 81

On all electronic claims:
The Humana Healthy Horizons in Ohio Member ID number should go on:
- 2010BA Loop = Subscriber name
- NM109 = Member ID number

## Electronic Visit Verification (EVV)

Network providers are required to use, ODM's electronic visit verification (EVV) system, or an alternative EVV system certified by ODM's EVV vendor, for the following services, or as otherwise specified by ODM:
- Home health aide G0156
- Nursing RN G0299
- Nursing LPN G0300
- Private duty nursing/independent nursing T1000
- Registered nurse assessment T1001
- Nursing RN T1002
- Nursing LPN T1003
- Home care attendant S5125
- Personal care aide T1019
- Waiver services not otherwise specified T2025
- Physical therapy G0151
- Occupational therapy G0152
- Speech language pathology G0153

The data collected from the EVV data collection system is used to validate all claims against EVV data (100% review) during the claim adjudication process.

Providers that need assistance on using the EVV data collection system can call Provider Services at **877-856-5707**

## Out-of-network Claims

Humana Healthy Horizons in Ohio established guidelines for payments to out-of-network providers for pre-authorized medically necessary services. These services are reimbursed at no less than 100% of the Ohio Medicaid fee schedule. If the service is not available from an in-network provider, Humana Healthy Horizons in Ohio may reimburse that provider less than the Medicaid Fee for Service rate.

## Claim Processing Guidelines

**Coordination of Benefits**
- COB requires a copy of the appropriate Remittance Statement from the primary carrier payment:
  - Electronic claims
  - Primary carrier's payment information
  - EOB from primary carrier
- Medicare COB claims - Appropriate Remittance Statement must be received within 90 days of the last submission.
- Non-Medicare primary payer – Appropriate Remittance Statement must be received within 90 days from date of service or discharge.
- If a claim is denied for COB information needed, the provider must submit the appropriate Remittance Statement from the primary payer within the remainder of the initial claims timely filing period.

**Newborn Claims**

A child is automatically eligible for medical assistance as of the child's date of birth, and remains eligible until the child reaches the age of one, provided the birth mother has applied for, been determined eligible for, and is receiving medical assistance on the date of the child's birth. A child also is covered, if labor and delivery services were

furnished prior to the date of application and the mother's Medicaid eligibility is based on retroactive coverage. This coverage for the mother continues for 12 months after the baby's birth.

**Other Claim Requirements**
Abortion, sterilization and hysterectomy procedure claims submissions must have consent forms attached.

The forms can be found at:

**Abortion:**
**medicaid.ohio.gov/static/Resources/Publications/Forms/ODM03197fillx.pdf**

**Sterilization:**
**www.hhs.gov/opa/sites/default/files/consent-for-sterilization-english-updated.pdf**

**www.hhs.gov/opa/sites/default/files/consent-for-sterilization-spanish-updated.pdf**

**Hysterectomy:**
**medicaid.ohio.gov/static/Resources/Publications/Forms/ODM03199fillx.pdf**

**medicaid.ohio.gov/static/Resources/Publications/Forms/Spanish/ODM03199SPA.pdf**

Claims indicating that a member's diagnosis was caused by the member's employment will not be paid. The provider should be advised to submit the charges to Workers' Compensation for reimbursement.

## Claims Compliance Standards

**Submitting Corrected Claims**
A corrected claim replaces a previously submitted claim and includes a change in the material information. Material information is information that could impact the way a claim is processed if that information were considered. If a healthcare provider identifies that a previously submitted claim is incorrect or incomplete, a corrected claim with accurate information should be submitted ODM's PNM.

**Please note:** For the Corrected claim, for HIPAA the 5010 format requires a 7 to be in the 3rd digit of the Type of Bill.

**Professional 837P – ASC X12 format: Loop 2300**

| | |
|---|---|
| Segment: CLM (claim information) | |
| • CLM01 (claim submitter's identifier) | |
| • CLM02 (monetary amount) | |
| • CLM05 (healthcare service location information) | |
| – CLM05 – 1 (facility code value) | *Place of service code |
| – CLM05 – 2 (facility code qualifier) | *Place of service codes for professional or dental services |
| – CLM05 – 3 (claim frequency type code) | *For corrected claim, populate with a value of 7 |
| • CLM06 (yes/no condition or response code) | *Physician or supplier signature indicator |
| • CLM07 (physician accepts assignment code) | *Assignment or plan participation code |
| • CLM08 (yes/no condition or response code) | *Benefits assignment certification indicator |
| • CLM09 (release of information code) | |
| Segment: REF (Payer claim control number) | |
| • REF01 (reference identification qualifier) | *Original reference number |
| • REF02 (reference identification) | *Payer claim control number |

**Institutional 837I – ASC X12 format: Loop 2300**

| Segment: CLM (claim information) | |
|---|---|
| • CLM01 (claim submitter's identifier) | |
| • CLM02 (monetary amount) | |
| • CLM05 (healthcare service location information) | |
| – CLM05 – 1 (facility code value) | *Facility type code |
| – CLM05 – 2 (facility code qualifier) | *Uniform billing claim form bill type |
| – CLM05 – 3 (claim frequency type code) | *For corrected claim, populate with a value of 7 |
| • CLM07 (physician accepts assignment code) | *Assignment or plan participation code |
| • CLM08 (yes/no condition or response code) | *Benefits assignment certification indicator |
| • CLM09 (release of information code) | |
| Segment: REF (payer claim control number) | |
| • REF01 (reference identification qualifier) | *Original reference number |
| • REF02 (reference identification) | *Payer claim control number |

**ASC X12 format (electronic method)**
**Please note, Humana prefers to receive corrected claims electronically.**

If you have additional questions about corrected claims, please follow industry guidance according to the Health Care Claim Implementation Guide, using 837P for professional claims or 837I for institutional claims. For more information on Health Insurance Portability and Accountability Act of 1996 (HIPAA) X12 837 Health Care Claim transactions, please visit the Washington Publishing Company (WPC) site at **www.wpc-edi.com**.

## Coding and Payment Policies

Humana Healthy Horizons in Ohio strives to be consistent with applicable federal and Ohio Department of Medicaid requirements and with appropriate national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code/code set(s) submitted and related clinical standards for a claim received electronically or as a hardcopy.

We expect submitters to comply with applicable HIPAA based requirements, including the use of HIPAA mandated code sets (for example, HCPCS Level II, CPT, and ICD-10-CM). To that end, we apply HIPAA standards to all electronically received claims.

In addition, Humana Healthy Horizons in Ohio applies relevant guidance from the Centers for Medicare & Medicaid (CMS), including National Correct Coding Initiative (NCCI) edits.

Finally, generally accepted commercial health insurance rules regarding coding and reimbursement also are used when appropriate.

To determine unit prices for a specific code or service, please visit **Medicaid NCCI Reference Documents | CMS**.

Humana Healthy Horizons in Ohio uses coding industry standards, such as the American Medical Association (AMA) CPT manual, NCCI and relevant guidance from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including, but not limited to:

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

Humana Healthy Horizons in Ohio seeks to apply fair and reasonable coding edits. We maintain a provider disputes function that reviews, on request, the application of individual edits to a claim. Those reviews account for applicable standards, including specific types of standards discussed above. To ensure all relevant information is considered, relevant clinical information should be included with a dispute request. The Humana Healthy Horizons in Ohio Disputes team uses relevant clinical information to consider why the claim, as submitted, is not consistent with the edit logic that was applied, and to determine whether that clinical information indicates a reasonable exception to the norm and justifies removal of the edit in a particular case.

## Suspension of Provider Payments

A network provider's claim payments are subject to suspension when ODM, Division of Program Integrity has notified Humana Healthy Horizons of Ohio.

## Coordination of Benefits (COB)

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

- COB requires a copy of the appropriate Remittance Statement from the primary carrier processing:
  - Claims - primary carrier's payment information
- Healthy Horizon in Ohio's timely filing limits for provider claims shall be at least 90 days from the date of the remittance advice that indicates adjudication or adjustment of the third-party claim by the third-party payer
- If a claim is denied for COB information needed, the provider must submit the appropriate Remittance Statement from the primary payer within the remainder of the initial claims timely filing period

## COB Overpayment

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

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

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

## Missed Appointments

In compliance with federal and state requirements, Humana Healthy Horizons in Ohio members cannot be billed for missed and/or cancelled appointments. Humana Healthy Horizons in Ohio encourages members to keep scheduled appointments and to call to cancel ahead of time, if needed.

## Member Termination Claim Processing

**From Humana Healthy Horizons in Ohio to another plan**
In the event of a member's termination of enrollment with Humana Healthy Horizons in Ohio into a different Medicaid plan, Humana Healthy Horizons in Ohio may submit voided encounters and notify providers of adjusted claims using the following process:

- Humana Healthy Horizons in Ohio determines whether claims were paid for dates of service in which the member was afterward identified as ineligible for Medicaid benefits with Humana Healthy Horizons in Ohio.
- Humana Healthy Horizons in Ohio sends out a notice to each affected provider that recoupment of payment will occur for the claim(s) identified in the recoupment letter. The provider is allowed 30 calendar days from receipt of the letter to respond to the notice.
- Once the minimum 30 calendar days expires, if the affected provider has not attempted to appeal the recoupment of payment or has not submitted a refund check, Humana Healthy Horizons in Ohio adjusts the payment(s) for the affected claims listed in the notice letter.

**From another plan to Humana Healthy Horizons in Ohio**
If a member was previously enrolled with another Medicaid plan and is now eligible with Humana Healthy Horizons in Ohio, providers are required to submit a copy of the EOP reflecting recoupment of payment and documentation from the previous MCO to validate the original encounter has been voided and accepted by ODM.

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

## Provider Disputes

A provider dispute may be filed via telephone, online, by mail or in person.

On receipt of a dispute, the assigned Provider Dispute Resolution team will investigate each dispute applying any applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying Humana's written policies and procedures. The Provider Dispute Resolution team will resolve the issue within the time period identified in the table "Dispute Q&A" below.

Provider claim disputes are any provider inquiries, complaints, or requests for reconsiderations ranging from general questions about a claim to a provider disagreeing with a claim denial. While these disputes can come in through any avenue (e.g., provider call center, provider advocates, MCO's provider portal), they do not include

inquiries that come through ODM's ProviderWeb portal (HealthTrack).

Disputes can be submitted using the following steps:

- Electronically, via Availity Essentials – **Availity.com**
- Verbally, via telephone, by calling **877-856-5707**. Hours of operation are 7 a.m. to 8 p.m., Eastern time, Monday through Friday.
- In writing, via mail:
  **Humana Healthy Horizons in Ohio**
  Attn: Provider Disputes
  P.O. Box 14601
  Lexington, KY 40512-4601
- Verbally in person
- Via a visit with a Provider Relations representative or other Humana staff member (e.g., care manager, nurse, etc.)
- Via a Humana Ohio office

| Claims Dispute FAQ Topic | Response |
|---|---|
| How can disputes be submitted? | • Electronically, via Availity Essentials – **Availity.com**<br>Use the Claim Status tool to locate the claim and select the "Dispute Claim" button. Then go to the request in the Appeals worklist to supply all needed information and submit the dispute to Humana<br>• Verbally, via telephone by calling **877-856-5707**.<br>Hours of operation are 7 a.m. to 8 p.m., Eastern time, Monday through Friday.<br>• In writing, via mail:<br>**Humana Healthy Horizons in Ohio**<br>Attn: Provider Disputes<br>P.O. Box 14601<br>Lexington, KY 40512-4601<br>• Verbally, in person<br>• Via a visit with a Provider Relations representative or other Humana staff member (e.g., care manager, nurse, etc.)<br>• Via a Humana Ohio office |
| What is the time frame for a provider to submit a claims dispute? | Providers must file claim dispute no later than 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later |
| What communication and resolution time frame can be expected? | Written complaints:<br>• An acknowledgement letter within five business days of receipt of the dispute.<br>• A resolution letter within 15 business days of receipt.<br>• A status letter may be sent every five business days starting on the 15th business day until the dispute is resolved.<br>Verbal disputes:<br>• An acknowledgement letter is sent within five business days notifying the provider of receipt. If a dispute is through Provider Services call center and resolved during first call resolution no additional follow-up with the provider is needed.<br>• A resolution letter within 15 business days of receipt; if not resolved on the initial phone call.<br>• A status letter may be sent every five business days starting on the 15th business day until the dispute is resolved.<br>Digital disputes:<br>• An acknowledgement letter within five business days of receipt of the dispute.<br>• A resolution letter within 15 business days of receipt.<br>• A status letter may be sent every five business days starting on the 15th business day until the dispute is resolved. |

The information included in the submission should include:

- Name of person calling, submitting or speaking, including phone number and/or email
- Provider/facility Tax ID number
- Provider/facility name
- Member ID and name
- Claims number(s)
- Authorization/referral number(s)
- Details of dispute/issues

# Care Coordination/Care Management for Physical Health and Behavioral Health

## Description of the Care Coordination and Care Management Programs

Humana Healthy Horizons in Ohio members have access to care managers who provide a holistic approach to addressing physical and behavioral healthcare needs as well as social determinant issues. We recognize that members who experience complex behavioral health needs often have strong, established relationships with their care providers. Rather than disrupt these relationships with our own personnel, our Comprehensive Care Services (CCS) team structure incorporates and supports existing case management services provided to our members through our network providers, OhioRISE, state agencies or community-based organizations. This coordination is enhanced through data-sharing via our provider portal, support through our provider communication lines, and participation in multi-disciplinary care team (MDT) meetings led by our Care Management team or provider led case management team (BHCC / CME/ CCE), based on member preference and need.

## Collaboration with OhioRISE/CMEs

Providers may submit referrals for member evaluations for OhioRISE to **OHMCDOhioRISE@humana.com**. Humana's Care Coordination staff will outreach the member and their family to coordinate a timely CANS assessment to determine OhioRISE eligibility. An individual who is enrolled in the OhioRISE program will keep their managed care enrollment for their physical health benefit. Humana will collaborate with the member's OhioRISE care team and participate in the OhioRISE Child and Family Team meetings based on the member's needs and choice.

Humana Healthy Horizons in Ohio also offers chronic condition management programs for behavioral health and substance use. Humana Healthy Horizons in Ohio's providers may contact Humana Healthy Horizons in Ohio to refer members needing care management assistance by calling **877-856-5702** or via email **OHMCDCareManagement@humana.com**. Humana Healthy Horizons in Ohio adheres to a "no-wrong door approach" to care management referrals.

**Provider Coordination for Behavioral Health**

Network providers are required to coordinate care when members are experiencing behavioral health conditions that require ongoing care.

Primary care providers are required to:

- Provide basic behavioral health services to members to include
  - Screening for mental health and substance use issues during routine and emergent visits
  - Prevention and early intervention
  - Medication management
  - Treatment for mild to moderate behavioral health conditions
- Request consultation and refer to specialized behavioral health services for severe or chronic behavioral health conditions.
- Follow up with behavioral health providers to coordinate integrated and non-duplicitous care to the member
- Obtain necessary signed release of information for sharing of personal health information including compliance with 42CFR Part II requirements around behavioral health and substance use disorder.

Behavioral health providers are required to:

- Notify the primary care provider (PCP) when a member initiates behavioral health services with the provider
- Prior to sharing information with the primary care provider, obtain signed release of information for sharing of personal health information in compliance with 42CFR Part II requirements around behavioral health and substance use disorder.
- Provide initial and summary reports to the primary care provider (after receiving above release of information)
- Refer members with known or suspected and/or untreated physical health problems or disorders to their PCP for examination and treatment, with the member's or the member's legal guardian's consent. Behavioral health providers may only provide physical healthcare services if they are licensed to do so.

Humana Healthy Horizons in Ohio assists with provider referrals, scheduling appointments and coordinating an integrated approach to the member's health and wellbeing by coordinating care between behavioral health providers, PCPs and specialists.

**Continuation of Treatment for Behavioral Health**

For members receiving inpatient behavioral health

services, Humana Healthy Horizons in Ohio requires providers to schedule an outpatient follow-up appointment prior to the member's discharge from the facility. The outpatient follow-up must be scheduled to occur within seven days from the date of discharge. Behavioral health providers are expected to contact members within 24 hours of a missed appointment to reschedule.

Humana Healthy Horizons in Ohio case managers are available to promote a holistic approach to addressing a member's physical and behavioral healthcare needs as well as social determinant issues. We offer chronic condition management programs for behavioral health and substance use, as well as care management programs based upon the member's level of need. Humana provides comprehensive and integrated care management services through medical and behavioral health nurses, social workers, licensed behavioral health professionals and outreach specialists. We provide personal member interaction and connect members with community-based resources to address social determinants of health needs such as food pantry access and utility assistance.

## Role of Provider in Care Coordination and Care Management Programs in Accordance with OAC rule 5160-26-05.1

Providers are responsible for identifying members that meet Humana's care management criteria.

- High Risk Maternity
- Multiple uncontrolled chronic conditions
- Homelessness
- Active Substance Use Disorder
- Children enrolled in Early Intervention
- Serious and Persistent Mental Illness (SPMI)
- High persistent unmet social needs

The process for the provider to follow in notifying the MCO when such members are identified.

Providers may contact Humana Healthy Horizons in Ohio to refer members needing care management assistance by calling **877-856-5707** or via email at:

- **Medical Care Management: OHMCDCareManagement@humana.com**.
- **Behavioral Health Care Management: OHMCDCareManagement_BH@humana.com**.

Humana Healthy Horizons in Ohio adheres to a no-wrong-door approach to care management referrals, assisting with provider referrals, appointment scheduling and coordination of an integrated approach to the member's health and well-being. Behavioral health providers are required to send initial and quarterly summary reports to the member's PCP and to refer members to PCP for untreated physical health concerns to better coordinate care between behavioral health providers, primary care providers and specialists.

**Services**

- Care guide support for low-risk members
- Care management for moderate-risk members
- Intensive care management for high-risk members
- Complex care management for complex members
- Transitional care management
- Behavioral health and substance-use services
- HumanaBeginnings® prenatal program
- Chronic condition management program

**High-risk Members**

Members in complex care management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. Members involved in this level of care management receive, at a minimum, monthly contacts to review plans of care and quarterly re-assessment for changing needs.

Care management activities may integrate community health worker, peer or specialist support. Case managers focus on implementing the member's plan of care, preventing institutionalization and other adverse outcomes, and supporting the member in self-managing his or her care goals.

**Prenatal Care Management**

Humana's HumanaBeginnings® program provides perinatal and neonatal care management. Nurses are available to help manage high-risk pregnancies and premature births by working in conjunction with providers and members. The program is open to any pregnant member who would like to participate. Referrals to HumanaBeginnings® can be sent via email to: **OHMCDMaternity@humana.com**

**Ohio Medicaid Pregnancy Notifications**

There are two sources for notification of pregnancy:

1. Report of Pregnancy (ROP) – Early pregnancy notification that is submitted only once by any non-obstetrical services provider that initially identifies a member is pregnant. Provider types include:
   a. Local Health Departments (LHDs)
   b. Primary care providers
   c. Emergency department providers
   d. Community clinics
   e. Ohio Equity Institute (OEI) Community Based Organizations
2. Pregnancy Risk Assessment Form (PRAF) – Submitted by obstetrical services providers during the first prenatal visit or when there is a significant change in medical condition, risk factors or needs.

**Electronic ROP and electronic-PRAF (e-PRAF)**
Submission of the electronic ROP and e-PRAF/e-PRAF 2.0 via NurtureOhio has multiple benefits with one, simple submission:

- Ensures pregnant members maintain Medicaid eligibility
- Streamlines communications among multiple entities, facilitating connection of pregnant members to needed services
- Provides an automatic referral to home health agency for high-risk progesterone candidates, ODH Home Visiting and Women, Infant and Children (WIC)

**NurtureOhio submission**

1. Open the NurtureOhio website to access the notification forms: **progesterone.nurtureohio.com/login**
2. Instructions can be found at: **medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/praf/praf**
3. Users must be registered in the Medicaid Information Technology System (MITS). For username or password issues: **www.ohmits.com/**
4. Difficulties with NurtureOhio, email: **Progesterone_PIP@medicaid.ohio.gov**

**Enhanced reimbursement for electronic submission**
Electronic ROP - Providers will receive a $30 payment when the claim is coded with HCPS Code T1023.
e-PRAF – Providers will receive a $90 payment when the claim is coded with HCPS Code H1000 with modifier 33.

For more information, including paper forms and how to submit please visit: **medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/special-programs-and-initiatives/praf/praf**

PRAF submissions are important for the care and referral of patients, and to help moms receive the best support for a healthy pregnancy. When vital information is missing it prevents optimum care of mom and baby. Please fill in each blank on the form.

**Submitting the PRAF 2.0 using NurtureOhio is Easy!**

5. Open the NurtureOhio website to access the PRAF: **www.nurtureohio.com**
6. Instructions can be found at: **medicaid.ohio.gov/Provider/PRAF**
7. Users must be registered in the Medicaid Information Technology System (MITS). For username or password issues: **www.ohmits.com/**
8. Difficulties with NurtureOhio, email: **Progesterone_PIP@medicaid.ohio.gov**

**Claims submission instructions for obstetrical services providers**
When submitting claims service code H1000 with modifier 33 should be used to indicate that an electronic-PRAF (e-PRAF) has been completed in NurtureOhio in order to receive the enhanced rate of $90.00 (OAC 5160-1-60).

**Provider Benefits of submitting a PRAF**
The electronic PRAF 2.0 (e-PRAF) has multiple benefits with one, simple submission:

- notifies the Ohio Department of Job and Family Services County Office, Managed Care Plan, and Home Health Care provider of the pregnancy, need for progesterone and any other need indicated on the form. The paper form needs faxed in order to do this.
- Allows for an Ohio Board of Pharmacy approved Progesterone prescription to be printed and faxed to the appropriate pharmacy.
- Allows provider staff updates by multiple users prior to submission.
- Maintains a pregnant woman's Medicaid eligibility without disruption in coverage-equating to prompt provider payment for services throughout mom's pregnancy.

**Ensuring Prompt Care** Every pregnant woman with Medicaid coverage should be linked to needed services on her very first prenatal visit. An online PRAF 2.0 submission ensures:

- Medicaid coverage for Mom and baby without disruption through the immediate post-partum period.
- Serves as pregnancy notification to managed care plans and initiation of timely health care and connection to added resources, like care management, important for at-risk pregnancies.

**Neonatal Intensive Care Unit (NICU) Care Management Program**
Humana's NICU case managers provide telephone-based services for the parents of eligible infants admitted to a NICU.

Case managers in the Humana NICU Case Management Program are registered nurses who help families understand the treatment premature babies receive while they are in the hospital and prepare to care for the infants at home. They engage families during and after the baby's hospital stay. Case managers work closely with physicians and hospital staff to coordinate care during the infant's stay in the hospital and after discharge. They also help parents arrange for home health nurses, ventilators, oxygen, apnea monitors and other equipment and services needed to care for the infant at home. After the infant is discharged from the hospital, nurses call the family to

provide additional support. For more information about this program, please call **855-391-8655**. Hours of operation are Monday through Friday, 8 a.m. to 6 p.m., Eastern time.

**Population Health Module**

The Population Health module helps physicians in monitoring the clinical measures that are identified and executed for the members assigned to them. Providers can access the Population Health Module by logging into Availity and navigating to the Humana Payer Spaces Section to view Resources. Ohio Medicaid Care Management link will then direct providers to the Population Health Dashboard. This allows providers to view member's assessments, care plans, authorizations, ADT, assigned Care management program and Care manager contact information.

The Population Health Module allows successful population health management, by involving physicians in a patient's care team, while also giving providers the ability to track the clinical measures being taken for patient's health improvement through care management.

### Health Education

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

## Reporting

### Member medical records – MCO's documentation, legibility, confidentiality, maintenance, and access standards for member medical records; member's right to amend or correct medical record in accordance with OAC rule 5160-26-05.1

Providers shall maintain a comprehensive health record that reflects all aspects of care for each member. Providers shall maintain medical records in a secure, timely, legible, current, detailed, accurate and organized manner to permit effective and confidential patient care and quality review. Providers must have a process for members to amend or correct their medical records in accordance with OAC rule 5160-26-05.1. Records should be safeguarded against loss, destruction or unauthorized use and must be accessible for review and audit. Such records shall be readily available to ODM and/or its designee and contain all information necessary for the medical management of each Medicaid member.

Providers must maintain individual health records for each Medicaid member. Procedures should also exist to facilitate the prompt transfer of patient care records to other in- or out-of-plan providers.

**Standards for Member Medical Records**

- Member/patient identification information on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information
- Date of data entry and date of encounter
- Provider identification by name
- Allergies, adverse reactions and all known allergies noted in a prominent location
- Past medical history, including serious accidents, operations and illnesses
- For children, past medical history includes prenatal care and birth information, operations and childhood illnesses (e.g., documentation of chickenpox)
- Identification of current problems
- Consultation, laboratory and radiology reports filed in the medical record containing the ordering provider's initials or other documentation indicating review
- Documentation of immunizations
- Identification and history of nicotine, alcohol use or substance abuse
- Follow-up visits provided secondary to reports of emergency room care
- Hospital discharge summaries
- Advanced medical directives (for adults)
- All written denials of service and reasons for denials
- Signature and title or initials of the provider rendering the service. If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials.
- Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer are evaluated by another reviewer

A member's medical record must include the following minimal detail for individual clinical encounters:

- History and physical examination for presenting complaints, containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health and substance abuse status

- Diagnosis or medical impression
- Objective finding
- Assessment of patient's findings
- Unresolved problems, referrals and results from diagnostic tests, including results and/or status of preventive screening services (i.e., EPSDT) are addressed from previous visits
- Plan of treatment, including:
- Medication history, medications prescribed, including the strength, amount, directions for use and refills
- Therapies and other prescribed regimen
- Health education provided
- Follow-up plans including consultation and referrals and directions, including time to return

A member's medical record must include, at a minimum, the following for hospital and mental hospital visits:

- Identification of the beneficiary
- Physician name
- Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 42 C.F.R. 456.172 (behavioral health hospitals) or 42 C.F.R. 456.70 (hospitals)
- Initial and subsequent continued stay review dates (described under 42 C.F.R. 456.233 and 42 C.F.R. 465.234 [for behavioral health hospitals] and 42 C.F.R. 456.128 and 42 C.F.R. 456.133 [for hospitals])
- Reasons and plan for continued stay if applicable
- Other supporting material appropriate to include
- For non-behavioral health hospitals only:
  - Date of operating room reservation
  - Justification of emergency admission, if applicable

The member's medical record is the property of the provider who generates the record. Medical records generally should be preserved and maintained by the provider for a minimum of five years unless federal requirements mandate a longer retention period (i.e., immunization and tuberculosis records are required to be kept for a person's lifetime).

PCPs and obstetrics and gynecology (OB-GYNs) providers acting as PCPs, may be reviewed for their compliance with medical record documentation standards. Identified areas for improvement are tracked and corrective actions are taken as indicated. Effectiveness of corrective actions is monitored until problem resolution occurs.

Confidentiality of member information must be maintained at all times. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to Humana Healthy Horizons in Ohio, or its representatives, without a fee to the extent permitted by state and federal law. Providers shall have procedures in place to permit the timely access and submission of health records to Humana Healthy Horizons in Ohio on request. Information from the health records review may be used in the re-credentialing process.

## Policies and Procedures for MCO Action in Response to Undelivered, Inappropriate, or Substandard Health Care Services in Accordance with OAC rule 5160-26-05.1

Humana Healthy Horizons in Ohio complies with the federal Health Care Quality Improvement Act and has an active peer review committee.

It is the policy of Humana Healthy Horizons in Ohio:

- To improve the quality and safety of health care services provided to our members by our providers through a Provider Quality Review Process and other Humana quality management processes
- To investigate select episodes of care to determine if intervention is appropriate
- To intervene as necessary to bring about provider improvement in care, to protect members, or both;
- To offer an opportunity for a hearing and review when Humana Healthy Horizons in Ohio recommends certain actions that may adversely affect a provider's status for more than 30 days
- To treat and manage confidentially all information, documents, records and reports relating to this and other quality management processes

Interventions may take many forms, including corrective action plans, limitations on provider status, suspensions or termination. Humana Healthy Horizons in Ohio reports all individual providers who resign after the Provider Quality Review process has begun to the National Practitioner Data bank. Humana Healthy Horizons in Ohio complies with the specific laws of the state in which the activity takes place, including any reporting requirements. To the extent that Humana Healthy Horizons in Ohio 's policy is inconsistent with the laws of the state in which review takes place, state law governs.

To comply with the requirements of accrediting and regulatory agencies, Humana Healthy Horizons in Ohio adopted certain responsibilities for participating providers that are summarized below. This is not a comprehensive, all-inclusive list. Additional responsibilities are presented elsewhere in this manual and in the Humana Health Plan provider agreement.

**Providers must:**

- Have a professional degree and a current, unrestricted license to practice medicine in the state in which provider's services are regularly performed.

- Agree to comply with Humana Healthy Horizons in Ohio's quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by Humana Healthy Horizons in Ohio.
- Maintain full participation status in the Ohio Medicaid program with ODM.
- Certify that the provider and its principals, employees, agents and subcontractors are not excluded, suspended, or debarred from participation in any federal health care program or the Ohio Medicaid program.
- Be credentialed by Humana Healthy Horizons in Ohio and meet all credentialing and re-credentialing criteria as required by Humana Healthy Horizons in Ohio and ODM.
- Provide documentation on their experience, background, training, ability, malpractice claims history, disciplinary actions or sanctions, and physical and mental health status for credentialing purposes.
- Possess a current, unrestricted Drug Enforcement Administration (DEA) certificate, if applicable and/or a state Controlled Dangerous Substance (CDS) certificate or license, if applicable.
- Have a current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.
- Be a medical staff member in good standing with a participating network hospital(s) if he/she makes plan member rounds and has no record of hospital privileges being reduced, denied or limited, or if so, provide an explanation that is acceptable to the plan.
- Comply with all state and federal law/requirements for database screening and criminal background checks of new hires and current employees and staff who have direct contact with Humana Healthy Horizons in Ohio members and/or access to Humana Healthy Horizons in Ohio members' protected health information. Participating providers are prohibited from employing or contracting with individuals or entities that are excluded or debarred from participation in Medicare, Medicaid or any federal healthcare program. Participating providers are required to conduct initial screenings and criminal background checks and to comply with ongoing monitoring requirements of all employees and contractors in accordance with state and federal law. The participating provider shall be required to immediately report to Humana Healthy Horizons in Ohio any exclusion information discovered. ODM reserves the right to deny enrollment or terminate a provider agreement with a participating provider as provided under state and/or federal law.
- Assume responsibility for member's receiving post stabilization care at a hospital at which the provider has privileges until either the member is transferred, agreement is reached between the treating provider and Humana Healthy Horizons in Ohio concerning the member's care, or discharged.
- Inform Humana Healthy Horizons in Ohio in writing within 24 hours of any revocation or suspension of his/her Bureau of Narcotics and Dangerous Drugs number and/or of suspension, limitation or revocation of his/her license, reduction and/or denial of hospital privileges, certification, CLIA certificate or other legal credential authorizing him/her to practice in any state in which the provider is licensed.
- **Inform Humana Healthy Horizons in Ohio immediately** of changes in licensure status, Tax Identification Numbers, NPI, telephone numbers, addresses, status at participating hospitals, provider status (additions or deletions from provider practice), loss or decrease in amounts of liability insurance below the required limits and any other change which would affect his/ her participation status with Humana Healthy Horizons in Ohio.
- Not discriminate against members as a result of their participation as members, their source of payment, age, race, color, national origin, religion, sex, sexual preference, health status or disability.
- Meet the requirements of all applicable state and federal laws and regulations, including Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973.
- Serve the target population.
- Assure the availability of services to Humana Healthy Horizons in Ohio members 24 hours a day, seven days a week when medically necessary.
- Arrange for on-call and after-hours coverage by a participating and credentialed Humana Healthy Horizons in Ohio physician. (After-hours voicemail is not acceptable.)
- Refer members only to participating providers, except when participating providers are not reasonably available or in an emergency.
- Admit members only to participating network hospitals, skilled nursing facilities and other facilities and work with hospital-based physicians at participating hospitals or facilities in cases of need for acute hospital care, except when participating providers or facilities are not reasonably available or in an emergency.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from,

or have any recourse against any Humana Healthy Horizons in Ohio member, other than for copayments, deductibles, coinsurance or other fees that are the member's responsibility under the terms of their benefit plan.
- Provide services in a culturally competent manner, (i.e., removing all language barriers, arranging and paying for interpretation services for limited English proficient [LEP] and the hearing/visually impaired) as required by state and federal law. Care and services should accommodate the special needs of ethnic, cultural and social circumstances of the patient. (Additional information and resources for delivering culturally competent care are available from the U.S. Department of Health and Human Services, Office of Minority Health at **minorityhealth.hhs.gov** and **thinkcultural health.hhs.gov/**.
- Provide or arrange for continued treatment to all members including, but not limited to, medication therapy, on expiration or termination of the agreement.
- Retain all agreements, books, documents, papers and medical records related to the provision of services to members as required by state and federal laws and in accordance with relevant Humana Healthy Horizons in Ohio policies.
- Treat all member records and information confidentially, and not release such information without the written consent of the member, except as indicated herein, or as allowed by state and federal law, including HIPAA regulations.
- Provide an electronic automated means, on request of Humana Healthy Horizons in Ohio and, at no cost for Humana Healthy Horizons in Ohio and all its authorized vendors acting on behalf of Humana Healthy Horizons in Ohio, to access member clinical information, including, but not limited to, medical records, for all payer responsibilities, including, but not limited to, case management, utilization management, claims review and audit and claims adjudication.
- Transfer copies of medical records for the purpose of continuity of care to other Humana Healthy Horizons in Ohio providers on request and at no charge to Humana Healthy Horizons in Ohio, the member or the requesting party, unless otherwise agreed.
- Submit a report of an encounter for each visit when the member is seen by the provider, if the member receives a Healthcare Effectiveness Data and Information Set (HEDIS®) service. Encounters should be submitted electronically or recorded on a CMS-1500 claim form and submitted according to the time frame listed in the agreement.
- Provider agrees to cooperate with and assist Humana Healthy Horizons in Ohio in its efforts to comply with its ODM contract and/or rules and regulations and to assist Humana Healthy Horizons in Ohio in complying with corrective action plans necessary for Humana Healthy Horizons in Ohio to comply with such rules and regulations.
- Review Ethics Every Day for Contracted Healthcare Providers and Business Partners.
- Understand and agree that nothing contained in the agreement or this manual is intended to interfere with or hinder communications between providers and members regarding a member's medical condition or available treatment options or to dictate medical judgment.
- Agree to submit a claim on behalf of the member in accordance with timely filing laws, rules, regulations and policies
- Agree and understand that provider performance data can be used by Humana Healthy Horizons in Ohio.
- Have an effective compliance program in place that include review and adherence to the requirements outlined within these separate Humana Healthy Horizons in Ohio documents:
  - Ethics Every Day for Contracted Healthcare Providers and Third Parties
  - Compliance Policy for Contracted Healthcare Providers and Third Parties
  - Completing the training documents above and adopting the documents, or having materially similar content in place, along with supporting processes, is a strong foundation to year-over-year compliance
  - These documents can be accessed at **Humana.com/providercompliance**.
- Take disciplinary action when your organization or we identify noncompliance, fraud or abuse.
- Notify us in a timely manner of suspected violations, misconduct or fraud, waste and abuse concerns and action(s) taken.
- Cooperate fully with any investigation of alleged, suspected or detected violations of applicable state or federal laws and regulations.
- Notify us if you have questions or need guidance for proper protocol.

## Reporting Provider Preventable Conditions (PPCs)/Hospital Acquired Conditions (HACs)

Humana Healthy Horizons in Ohio does not pay for services resulting from a provider preventable condition (PPC) as defined in 42 CFR 447.26: a condition that meets the definition of a "health care-acquired condition".

That also meets the following criteria:

a. Is identified in the Ohio Medicaid **state** plan;
b. Has been found by the **state**, based on a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
c. Has a negative consequence for the **beneficiary**;
d. Is auditable;
e. Includes, at a minimum, wrong surgical or other invasive procedure performed on a **patient**; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong **patient**.
f. Condition did NOT exist prior to the initiation of treatment by that provider.

Category 1 – Health Care-Acquired Conditions (For Any Inpatient Hospitals Settings in Medicaid)

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma; including fractures, dislocations, intracranial injuries, crushing injuries, burns, electric shock
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Manifestations of poor glycemic control including: diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity
- Surgical site infection following:
  - Coronary artery bypass graft (CABG) - mediastinitis
  - Bariatric surgery; including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery
  - Orthopedic procedures; including spine, neck, shoulder, elbow

Category 2 – Other Provider Preventable Conditions (For Any Health Care Setting)

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

Members access to care or services shall not be affected by the prohibition of payment.

Claims data is reviewed to identify services billed as a result of PPC. Identified claims are researched to determine if the claims were accurately billed as a PPC and ensure prohibition of payment of PPC services.

Humana Healthy Horizons in Ohio will implement vendor logic for the providers to self-report when a provider preventable condition has occurred.

## Incident Reporting

Providers are required to assure the immediate health and safety of members when becoming aware of any of the following critical incidents:

- Abuse
- Neglect
- Exploitation
- Misappropriation greater than $500
- Accidental/unnatural deaths
- Self-Harm or Suicide Attempt Resulting in ER/ Hospitalization
- Individual Lost or Missing
- Prescribed Medication Issues ( Provider error or Prescribed medication resulting in ER, EMS or Hospitalization)

If actions were not taken to assure the immediate health and safety of the member, the provider will do so immediately. Such actions may include calling police or EMS, reporting to county Adult Protective Services (APS), the county Public Child Services Agency (PCSA) or regulatory agencies such as the Ohio Department of Health. Providers are required to report these types of incidents to Humana Healthy Horizons within 24 hours of becoming aware of the incident by calling us at **877-856-5707**.

## How to Submit an Incident to the MCO

Critical incidents include, but are not limited to, abuse, neglect, exploitation, misappropriation greater than $500, accidental/unnatural death, self-harm or suicide with ER/ Hospitlaization, Missing or Lost individual, or prescribed medication issues as per Ohio Administrative Code 5160-44-05. Participating providers are required to report critical incidents to Humana Healthy Horizons in Ohio as soon as possible after the discovery of the incident, and no later than 24 hours after the critical incident occurred. Please call **877-856-5707** and be prepared to share the following details:

- Facts relevant to the incident, such as a description of what happened
- Incident type
- Date of the incident
- Location of the incident
- Names and contact information of all persons involved
- Any actions taken to ensure the health and welfare of the individual

Humana Healthy Horizons in Ohio and participating healthcare providers shall take immediate action, not to exceed 24 hours after an incident is discovered, to prevent further harm to any and all members and respond to any emergency needs of patients.

# Next Generation Managed Care Program

## OhioRISE

OhioRISE (Resilience through Integrated Systems and Excellence) is a specialized managed care program for youth with complex behavioral health and multi-system needs. ODM selected Aetna Better Health of Ohio to serve as the new OhioRISE specialized managed care organization. OhioRISE expands access to in-home and community-based behavioral health services and supports.

Aetna contracts with regional care management entities (CME) to ensure OhioRISE members and families have the resources they need to navigate their interactions with multiple state and local systems such as juvenile justice, child protection, developmental disabilities, mental health and addiction, education, and others. An individual who is enrolled in the OhioRISE program will keep their managed care enrollment for their physical health benefit. The managed care organization also will be included in the individual's care management.

**OhioRISE Eligibility:**

- Enrolled in Ohio Medicaid – either managed care or fee for service
- Be twenty years of age or younger at the time of enrollment
- Meet a functional needs threshold for behavioral health care, as identified by the Child and Adolescent Needs and Strengths (CANS) assessment tool, or the following:
  - an inpatient in a hospital with a primary diagnosis of mental illness or substance use disorder.
  - An inpatient in a psychiatric residential treatment facility (PRTF)
- Not be enrolled in a MyCare Ohio plan as described in Chapter 5160-58 of the Administrative Code

**OhioRISE Services:**

In addition to the behavioral health services provided through chapter 5160-27 of the Administrative Code, the following new services available through OhioRISE include:

- Care Coordination at three different levels:
  - Tier 1: Limited Care Coordination (LCC) delivered by Aetna for youth needing lower intensity care coordination
  - Tier 2: Moderate Care Coordination (MCC) will be consistent with principles of High-Fidelity Wraparound and will be delivered by a CME - qualified agency for youth with moderate behavioral health needs
  - Tier 3: Intensive Care Coordination (ICC) will be consistent with principles of High-Fidelity Wraparound and will be delivered by a CME - qualified agency for youth with the greatest behavioral health needs
- Intensive Home-Based Treatment (IHBT): OhioRISE will make changes to existing IHBT services and align with the Family First Prevention Services Act (FFPSA). As of July 1, 2022, IHBT will be exclusive to OhioRISE.
- Psychiatric Residential Treatment Facility (PRTF): Available as a designation in Ohio in 2023, this service is aimed at keeping youth with the most intensive behavioral health needs in-state and closer to their families and support systems.
- Mobile Response and Stabilization Service (MRSS): provide youth in crisis and their families with immediate behavioral health services to ensure they are safe and receive necessary supports and services (this new service will also be available to children who are not enrolled in OhioRISE).
- Behavioral Health Respite: provides short-term, temporary relief to the primary caregiver(s) of an OhioRISE plan enrolled youth, to support and preserve the primary caregiving relationship.
- Flex Funds: provides services, equipment, or supplies not otherwise provided through the Medicaid state plan benefit or the OhioRISE program that address a youth's identified need as documented in the child and family-centered care plan. These are intended to enhance and supplement the array of services available to a youth enrolled on the OhioRISE program.
- For additional services available for youth enrolled in the OhioRISE waiver see Ohio Administrative Code Rule 5160-59-05.

Additional information on the OhioRISE services is available in chapter 5160-59 of the Ohio Administrative Code.

Additional information regarding billing for behavioral health services provided to youth who are enrolled in the OhioRISE plan and information for providers to determine to which entity to submit claims is located in the OhioRISE Provider Enrollment and Billing Guidance and the OhioRISE Mixed Services Protocol on the **OhioRISE website**.

Aetna Better Health of Ohio can be reached by calling **833-711-0773** or e-mailing **OHRise-Network@aetna.com**.

**SPBM**

The Single Pharmacy Benefit Manager (SPBM) is a specialized managed care program operating as a prepaid ambulatory health plan (PAHP) that will provide pharmacy benefits for the entire Medicaid managed care population (excluding MyCare Ohio members). ODM selected Gainwell Technologies to serve as the SPBM. An additional integral component to the new pharmacy model is the Pharmacy Pricing and Audit Consultant (PPAC), which will conduct actual acquisition cost surveys, cost of dispensing surveys, and perform oversight and auditing of the SPBM. ODM has selected Myers and Stauffer, LC as the PPAC vendor.

The SPBM will consolidate the processing of pharmacy benefits and maintain a pharmacy claims system that will integrate with the Ohio Medicaid Enterprise System (OMES), new MCOs, pharmacies, and prescribers. The SPBM also will work with pharmacies to ensure member access to medications, supporting ODM's goals of providing more pharmacy choices, fewer out-of-network restrictions, and consistent pharmacy benefits for all managed care members. SPBM will also reduce provider and prescriber administrative burden, by using a single set of clinical policies and prior authorization procedures, as well as a single pharmacy program point of contact for all members.

All Medicaid managed care members will be automatically enrolled with the SPBM under a 1915(b) waiver. Additionally, Gainwell Technologies will be required to contract with all enrolled pharmacy providers that are willing to accept the SPBM contract terms, resulting in a broad pharmacy network that will ensure access for all members statewide.

SPBM will provide coverage for medications dispensed from contracted pharmacy providers. Provider-administered medications supplied by non-pharmacy providers (such as hospitals, clinics, and physician practices) will continue to be covered by the MCOs or the OhioRISE plan, as applicable.

For more information about the SPBM or PPAC initiatives, please email: **MedicaidSPBM@medicaid.ohio.gov** or visit the **SPBM website**.

# Quality Improvement

**Overview**

Humana Healthy Horizons in Ohio's Quality Improvement Program (QI Program) is a comprehensive quality improvement program that encompasses clinical care, preventive care, population health management and the health plan's administrative functions. It is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable medical and behavioral healthcare and services. Strategies are identified and activities implemented in response to findings. Using a continuous quality improvement methodology, the QI Program works to:

- Monitor system-wide issues
- Identify opportunities for improvement
- Determine the root cause of problems identified
- Explore alternatives and develop a plan of action
- Activate the plan, measure the results, evaluate effectiveness of actions, and modify the approach as needed

The QI Program activities include monitoring clinical indicators or outcomes, quality studies, HEDIS measures and/or medical record audits. The Quality Improvement Committee (QIC) is delegated by Humana's Board of Directors to monitor and evaluate the results of program initiatives and to implement corrective action when the results are less than desired or when areas needing improvement are identified. The QIC is accountable to Humana Healthy Horizons in Ohio Executive Management Team.

The goals of the QI Program are:

- Developing clinical strategies and providing clinical programs that look at the whole person, while integrating behavioral and physical health care.
- Identifying and resolving issues related to member access and availability to health care services.
- Addressing health care disparities and ensuring equitable access to and the delivery of services to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, or disabilities; and regardless of gender, sexual orientation, or gender identity.
- Providing a mechanism where members, practitioners, and providers can express concerns to Humana Healthy Horizons in Ohio regarding care and service.
- Monitoring coordination and integration of member care across provider sites.
- Monitoring, evaluating and improving the quality and appropriateness of care and service delivery to members through peer review, performance improvement projects (PIPs), medical/case record audits, performance measures, surveys, and related activities.
- Providing a comprehensive strategy for population health management that addresses member needs across the continuum of care.
- Developing QI activities and initiatives to improve population health outcomes.

- Providing mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.
- Guiding members to achieve optimal health by providing tools that help them understand their health care options and take control of their health needs.
- Adopting reimbursement models that incentivize the delivery of high-quality care.
- Promoting better communication between departments and improved service and satisfaction to members, practitioners, providers, and associates.
- Promoting improved clinician experience for physicians and all clinicians to promote member safety, provider satisfaction, and provider retention.

**Provider Participation in the Quality Improvement Program**

Network providers are contractually required to comply with Humana Healthy Horizons in Ohio's Quality Improvement Program, which includes providing member records for assessing quality of care. In addition, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule of 45 CFR 164.506 and rules and regulations promulgated thereunder (45 CFR Parts 160, 162, and 164) permits a covered entity (provider) to use and disclose protected health information (PHI) to health plans without member authorization for treatment, payment and healthcare operations activities. Healthcare operations include, but are not limited to, the health plan conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs, care management and care coordination. Providers also must allow Humana Healthy Horizons in Ohio to use provider performance data.

Humana Healthy Horizons in Ohio evaluates the effectiveness of the QI Program on an annual basis. Information regarding the QI Program is available on request and includes a description of the QI Program and a report assessing the progress in meeting goals.

An annual report is published which reviews completed and continuing QI activities and addresses the quality of clinical care and service, trends measures to assess performance in quality of clinical care and quality of service, identifies any corrective actions implemented or corrective actions which are recommended or in progress, and identifies any modifications to the QI Program. This report is available as a written document.

To receive a written copy of Humana Healthy Horizons in Ohio's Quality Improvement program and its progress toward goals, call us at **877-856-5707**.

**Member Satisfaction**

On an annual basis, Humana Healthy Horizons in Ohio conducts a member satisfaction survey of a representative sample of members. Satisfaction with access to services, quality, provider communication and shared decision-making is evaluated. The results are compared to Humana Healthy Horizons in Ohio's performance goals, and improvement action plans are developed to address any areas not meeting the standard.

**Clinical Practice Guidelines**

These protocols incorporate relevant, evidence-based medical and behavioral health guidelines from recognized sources such as professional medical associations, voluntary health organizations and NIH Centers and Institutes. Humana Healthy Horizons in Ohio considers the needs of our members when adopting guidelines. Contracted network providers and Humana Healthy Horizons in Ohio internal physicians from a cross section of disciplines review and approve adoption of the guidelines, and are reviewed quarterly. The guidelines help providers make decisions regarding appropriate healthcare for specific clinical circumstances. We strongly encourage providers to use and consider these guidelines whenever they promote positive outcomes for clients. The provider remains responsible for ultimately determining the applicable treatment for each individual.

The use of these guidelines allows Humana Healthy Horizons in Ohio to measure the impact of the guidelines on outcomes of care. Humana Healthy Horizons in Ohio monitors provider implementation of guidelines through the use of claim, pharmacy and utilization data. Areas identified for improvement are tracked and corrective actions are taken as indicated.

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

- Provider manual updates
- Provider communications
- Provider website

Providers also can receive preventive health and clinical practice guidelines through the care management department or their Provider Relations representative. Clinical practice guidelines also are available on our website at **Humana.com**.

**Healthcare Effectiveness Data and Information Set (HEDIS®)**

HEDIS is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. HEDIS includes care coordination measures for members transitioning from a hospital or

emergency department to home for which hospitals and providers have additional responsibilities. Humana Healthy Horizons in Ohio may conduct medical record reviews to validate HEDIS measures. In addition to medical record reviews, information for HEDIS is gathered administratively via claims, encounters and submitted supplemental data. There are two primary routes for supplemental data:

- Nonstandard supplemental data involves directly submitted, scanned images (e.g. PDF documents) of completed attestation forms and medical records. Nonstandard data also can be accepted electronically via a proprietary Electronic Attestation Form (EAF) or Practitioner Assessment Form (PAF). Submitted nonstandard supplemental data is subject to audit by a team of nurse reviewers before closing a HEDIS improvement opportunity.
- Standard supplemental data flows directly from one electronic database (e.g. population health system, EMR) to another without manual interpretation. Therefore, standard supplemental data is exempt from audit consideration. Standard supplemental data can be accepted via HEDIS-specific custom reports extracted directly from the provider's EMR or population health tool and is submitted to Humana Healthy Horizons in Ohio via either secure email or FTP transmission. Humana Healthy Horizons in Ohio also accepts lab data files in the same way. Humana Healthy Horizons in Ohio partners with various EMRs to provide member summaries and detail reports and to automatically retrieve scanned charts.

**External Quality Reviews**

ODM retains an external quality review organization (EQRO) for an annual external and independent review of the quality, outcomes, timeliness of, and access to services provided by Humana Healthy Horizons in Ohio, including medical record reviews for Humana Healthy Horizons in Ohio members. Participating providers are expected to partner with Humana Healthy Horizons in Ohio on any EQRO activities.

**Patient Safety to Include Quality of Care and Quality of Service**

Humana Healthy Horizons in Ohio supports implementation of a complete range of patient safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the healthcare network, utilization of evidence-based clinical guidelines to reduce practice variations, tracking and trending adverse events/quality of care issues and grievances related to safety and quality of care.

Patient safety is also addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:

- Regular checkups for adults and children
- Prenatal care for pregnant women
- Well-baby care
- Immunizations for children, adolescents, and adults
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, tests for sexually transmitted diseases, PAP smears and mammograms

Preventive guidelines address prevention and/or early detection interventions, and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices, and member needs.

Prevention activities include distribution of information, encouragement to use screening tools and ongoing monitoring and measuring of outcomes. While Humana Healthy Horizons in Ohio implements activities to identify interventions, the support and activities of families, friends, providers and the community have a significant impact on prevention.

## Quality Improvement Requirements

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

- Performance Improvement Projects (PIPs) – Ongoing measurements and interventions which seek to demonstrate 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 member satisfaction.
- Member Medical Record Reviews – Medical record reviews to evaluate documentation patterns of providers and adherence to member medical record documentation standards. Medical records may also be requested when investigating complaints of poor quality or service or clinical outcomes. Your contract with Humana Healthy Horizons in Ohio requires that you furnish member medical records to us for this purpose. Member medical record reviews are a permitted disclosure of a member's PHI in accordance with HIPAA. The record reviewers protect member information from unauthorized disclosure as set forth in the Contract and will ensure all HIPAA guidelines are enforced.

## Access Standards

Providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid managed care members. Participating PCPs and medical/behavioral health specialists are required to ensure adequate accessibility for healthcare 24 hours per day, seven days per week (24/7) when medically necessary. An after-hours PCP telephone number must be available to members. Voicemail is not permitted. Humana Healthy Horizons in Ohio's provider network must meet ODM's access standards as follows:

| Type of visit | Description | Minimum standard |
|---|---|---|
| Emergency service | Services needed to evaluate, treat, or stabilize an emergency medical condition. | 24 hours, 7 days/week |
| Urgent care (includes medical, behavioral health, and dental services) | Care provided for a non emergent illness or injury with acute symptoms that require immediate care; examples include but are not limited to sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain, and severe, non resolving headache. Includes acute illness or substance dependence that impacts the ability to function, but does not present imminent danger. | Within 24 hours, 7 days/week |
| Behavioral health non life threatening emergency | A non life threatening situation in which a member exhibits extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed. | Within 6 hours |
| Behavioral health routine care | Requests for routine mental health or substance abuse treatment from behavioral health providers. | Within 10 business days or 14 calendar days, whichever is earlier |
| CANS initial assessment | Assessment for the purposes of OhioRISE eligibility | Within 72 hours of identification |
| ASAM residential/inpatient services – 3: 3.1, 3.5, 3.7 | Initial screening, assessment and referral to treatment. | Within 48 hours of request |
| ASAM medically managed intensive inpatient services – 4 | Services needed to treat and stabilize a member's behavioral health condition. | 24 hours, 7 days/week |
| Primary care appointment | Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and PAP smears. | Within 30 calendar days |
| Non urgent sick primary care | Care provided for a non urgent illness or injury with current symptoms. | Within 3 calendar days |

| Type of visit | Description | Minimum standard |
|---|---|---|
| Prenatal care – First or second trimester | Care provided to a member while the member is pregnant to help keep member and baby healthy, including checkups and prenatal testing. | First appointment within 7 calendar days; follow up appointments no more than 14 calendar days after request |
| Prenatal care – Third trimester or high risk Pregnancy | | Within 3 calendar days |
| Specialty care appointment | Care provided for a non emergent/non urgent illness or injury requiring consultation, diagnosis, and/or treatment from a specialist. | Within 6 weeks |
| Dental appointment | Non emergent/non urgent dental services, including routine and preventive care. | Within 6 weeks of request |

These appointment availability standards do not replace the access requirements established by ODM for Comprehensive Primary Care (CPC) practices.

| | |
|---|---|
| 24/7 and same-day access to care | Practice offers at least one alternative to traditional office visits to increase access to the patient care team and clinicians in ways that best meet the needs of the population. This may include e-visits, phone visits, group visits, home visits, alternate location visits, or expanded hours in the early mornings, evenings, and weekends. Within 24 hours of initial request, the practice must provide access to a PCP with access to the member's medical record. The practice also must make clinical information of the member available through paper or electronic records, or telephone consultation to on-call staff, external facilities and other clinicians outside the practice when the office is closed. |

**PCP After-Hours Availability**

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

## Preventive Guidelines and Clinical Practice Guidelines

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

- Provider website at **Humana.com/provider/medical-resources/clinical/guidelines**
- Provider manual updates
- Provider communications

The protocols:

- Incorporate relevant, evidence-based medical and behavioral health guidelines from recognized sources, such as professional medical associations, voluntary health organizations and NIH Centers and Institutes
- Help providers make decisions regarding appropriate healthcare for specific clinical circumstances

We strongly encourage providers to use these guidelines to promote positive outcomes for patients. The provider ultimately remains responsible for determining the applicable treatment for each individual.

The use of these guidelines allows Humana Healthy Horizons in Ohio to measure the impact of the guidelines on outcomes of care. Humana Healthy Horizons in Ohio monitors provider implementation of guidelines through the use of claim, pharmacy and utilization data. Areas identified for improvement are tracked and corrective actions are taken as indicated.

## Fraud and Abuse Policy

Providers must incorporate a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse and subsequent correction of identified fraud or abuse into their policy and procedures. Contracted providers agree to educate their employees about:

- The requirement to report suspected or detected fraud, waste or abuse (FWA)
- How to make a report of the above
- The False Claims Act's prohibition on submitting false or fraudulent claims for payment, penalties for false claims and statements, whistleblower protections and each person's responsibility to prevent and detect FWA.

Humana Healthy Horizons in Ohio and Ohio Department of Medicaid should be notified immediately if a physician/provider or their office staff:

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

Providers may provide the above information via an anonymous phone call to Humana's Fraud Hotline at **800-614-4126**. All information is kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Humana ensures no retaliation against callers because Humana has a zero tolerance policy for retaliation or retribution against any person who reports suspected misconduct.

Providers also may contact Humana at **800-4HUMANA (800-448-6262)** or use the following contacts:

- Telephonic: SIU Direct Line: **800-558-4444** ext. 1500724 (8 a.m. to 5:30 p.m. Eastern time, Monday through Friday)
- SIU Hotline: **800-614-4126** (24/7 access)
- Ethics Help Line: **877-5-THE-KEY (877-584-3539)**
- Email: **SIUReferrals@humana.com** or **ethics@humana.com**
- Web: **Ethicshelpline.com** or **Humana.com**

Providers also may contact the ODM at **614-466-0722** or online at **medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-andpartners/helpfullinks/reporting-suspected-medicaid-fraud**

Ohio Attorney General's Office Medicaid Fraud Control Unit (MFCU) by phone at **800-642-2873** or online at **www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud**; and the Ohio Auditor of State (AOS) by phone at **866-FRAUD-OH** or by email at **fraudohio@ohioauditor.gov**.