2024 Provider Manual

Humana Healthy Horizons in South Carolina is a Medicaid product of Humana Benefit Plan of South Carolina Inc.

Humana Healthy Horizons in South Carolina | Healthy Connections

489801SC0624-B SCHM5FMEN

Table of contents

Welcome

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

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 members throughout the State of South Carolina.

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 improves the health of our members by using 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 South Carolina 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, with roots in Kentucky, 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 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 include 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 a member call center and a member 24-hour nurse advice line

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

- Case management
- Emergency department diversion
  - Higher than normal emergency department utilization (targeted at members with frequent utilization)
- Maternal and healthy baby program
- Discharge planning and transitional care support
- Disease management program for asthma and diabetes
- Disease management program for behavioral health and substance use

Mission Statement

Humana Healthy Horizons® is committed to helping members manage their healthcare costs, guiding consumers to make informed health and benefits decisions, and giving back to the communities we serve.

Humana Healthy Horizons is dedicated to our corporate mission and considers the unique needs of South

Carolinian providers and members. It is our goal to assist South Carolina by defining measurable results that will improve Medicaid MCO member access and satisfaction, maximize program efficiency, effectiveness, and responsiveness, and reduce operational and service costs.

Our Values

Humana is passionate about maintaining a foundation of our cultural evolution, which resides in our steadfast focus on living our values. These values are ingrained in our work, our strategies and our conversations.

- Caring. Create an environment where people feel valued, respected and are treated with kindness.
- Curious. Work and learn together creating the best solutions for the people we serve.
- Committed. To fulfill our purpose, take bold action to impact the lives of people and transform the healthcare industry.

Humana Healthy Horizons in South Carolina's Managed Care Plan

We are a community-based health plan that serves Medicaid members throughout South Carolina. We strive to support participating physicians and other healthcare providers because we believe strong collaborations help facilitate a high quality of care and a respectful member experience.

As a managed care organization (MCO), Humana improves the health of our members by utilizing an integrated, contracted network of high-quality providers. Network primary care providers (PCPs) provide a range of services themselves – including preventive healthcare and coordinated patient care – but also refer members to specialists, when necessary, to ensure timely access to appropriate preventive healthcare services.

Humana Healthy Horizons in South Carolina has the expertise, competencies and resources to achieve the following objectives:

- Advance evidence-based practices, high-value care and service excellence
- Support innovation and a culture of continuous quality improvement
- Ensure ready member access to care
- Improvement of member health
- Initiate a decrease in fragmentation and an increase in integration across providers and care settings, particularly for members with behavioral health needs
- Use a health information technology-supported approach to population health that's designed to:
  - maximize member health
  - advance health equity
  - address priority social determinants of health which include housing, food insecurity, physical safety and transportation
- Facilitate a straightforward decrease in administrative burden for providers and members
- Align financial incentives for MCOs and providers, per guidelines
- Build shared capacity to improve healthcare quality through data and collaboration
- Strive for a reduction of wasteful spending, abuse and fraud

Purpose of this Manual

Humana Healthy Horizons in South Carolina's Provider Manual has been designed to provide a guidance for network providers. It is an extension of the agreement between Humana and all provider types, including, but not limited to, physicians, hospitals and ancillary healthcare providers (hereinafter collectively and/or individually, as the context requires, referred to as "provider(s)"). Among topics addressed in this manual are services that are provided for members, policies and procedures related to the administration of the Humana network, and supplemental information meant to enhance and clarify provider contracts.

This manual may be revised periodically to provide new information and updates, noting that the web-based version will represent the latest update. Provider notices will be issued when updates are made to the provider manual.

Compliance and Ethics

At Humana, 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 all are responsible for complying with all applicable state and federal regulations along with applicable Humana Healthy Horizons policies and procedures.

This manual includes an overview of requirements to assure compliance and combat fraud, waste and abuse and references other, agreement-extension documents containing corresponding details.

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

- Formalizes Humana Healthy Horizons' 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 South Carolina 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:
- Have an effective compliance program
- Act according to professional ethics and business standards
- Conduct exclusion screenings
  - See Definitions section for more information about exclusion processes and lists
- Complete trainings required by Humana
- Conduct corresponding training of supporting healthcare practitioners and administrative staff supporting any function for Humana Healthy Horizons in South Carolina
- 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 **866-432-0001**.

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

Accreditation

Humana Healthy Horizons holds a strong commitment to quality as a fully accredited health plan by the National Committee for Quality Assurance (NCQA). We demonstrate our commitment through programs based on national standards, when applicable.

Communicating with Humana Healthy Horizons in South Carolina

Provider Services: 866-432-0001
(8 a.m. to 6 p.m., Monday through Friday)

Member 24-Hour Nurse Advice Line (24/7/365): 877-837-6952

Other helpful phone numbers:
- Prior authorization (PA) assistance for medical procedures and behavioral health: **866-432-0001**
- Prior authorization for pharmacy drugs: **800-555-2546**
- Pharmacy Help Desk: **800-865-8715**
- Medicaid case management: **866-432-0001**
- 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)**

Online - Availity Essentials
This secure provider portal offers convenient self-service tools for working online with Humana Healthy Horizons and other payers. Available features include:
- Eligibility and benefits lookup
- Member summary access
- Referrals and authorizations submission and review
- Claim status lookup
- Claim submission
- Remittance advice access
- Claim appeals/disputes submission and management
- Medical records submission and management
- Overpayment management
- Electronic remittance advice/electronic funds transfer (ERA/EFT) enrollment and management

To learn more about Availity Essentials, please call **800-282-4548** or visit Availity.com.

Mail
Correspondence
Humana Healthy Horizons in South Carolina
P.O. Box 14601
Lexington, KY 40512-4601

Provider Disputes
Humana Healthy Horizons in South Carolina
P.O. Box 14601
Lexington, KY 40512-4601

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

Humana Claims Office
Humana Healthy Horizons in South Carolina
P.O. Box 14601
Lexington, KY 40512-4601

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

Helpful websites
Providers may obtain plan information from Humana.com/HealthySC.

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

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

For help or more information regarding web-based tools, please call Provider Services at **866-432-0001**.

Member Enrollment and Eligibility

Medicaid eligibility

Medicaid eligibility is determined by the South Carolina Department of Health and Human Services (SCDHHS) in the member's county of residence.

SCDHHS provides eligibility information to Humana via an 834 file for members assigned to Humana. Eligibility begins on the first day of each calendar month for members joining Humana, with the exception of members otherwise identified by the state.

New member kits

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

The new member kit contains:

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

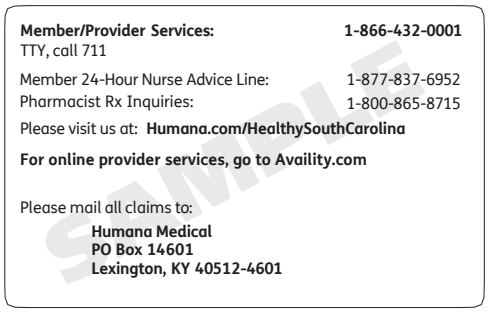
Member ID Cards

All new Humana Healthy Horizons members receive a Humana Healthy Horizons 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 member; it does not guarantee eligibility or benefits coverage. Members may lose Medicaid eligibility at any time; therefore, it is important to verify member eligibility prior to every service.

Card front:

Card back:



Front of SC MCD ID Card*

- Member ID – Humana UMID (Unique Member Identification #) required for claims
- Medicaid ID# – required for all members
- Effective Date – indicates when member becomes eligible for benefits
- RxBIN/RxPCN – needed for Pharmacy Benefits

Back of SC MCD ID Card*

- Member/Provider Service # – Toll Free # for Q&A's
- Pharmacist Rx Inquiries # – Toll Free # for Q&A's
- Availity.com – for online provider services
- Claims Address to submit paper claims – PO Box 14601 Lexington, KY 40512-4601

Verify eligibility

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

Before providing all services (except emergency services), providers are expected to verify member eligibility via the verification resources on the Availity Essentials secure provider portal.

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

Automatic primary care provider (PCP) assignment

A PCP is assigned automatically to all members. Humana's internal system can identify a member's previous PCPs within Humana's participating PCP panel and assist through auto assignment. Geographic assignment will be used when a member has no record of past PCP relationships within the participating Humana PCP panel. Humana's internal editing system also ensures that the auto assigned PCP is age-appropriate for the member, i.e. pediatricians will be assigned to pediatric members and adults assigned to a PCP who specializes in the treatment of adults. Members/providers may now fax requests to update their PCP. The new approved form can be found at: https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=5123820.

Disenrollment

Humana Healthy Horizons, SCDHHS or the member can initiate disenrollment. Members may disenroll from Humana Healthy Horizons for a number of reasons, including:

- Voluntary disenrollment within 90 days of initial enrollment with MCO
- MCO doesn't cover services requested by the member because of moral or religious objections
- Lack of access to MCO-covered services as determined by SCDHHS

Humana Healthy Horizons can initiate member disenrollment for the following reasons:

- The member dies
- The member becomes an Inmate of a public institution
- The member moves out of state or the contractor's service area
- The member elects hospice
- The member becomes Medicaid-eligible for institutionalization in a long-term care (LTC) facility/ nursing home for more than 90 consecutive days
- The member elects a home and community-based services (HCBS) waiver program
- The member becomes age 65 or older
- The member's behavior is disruptive, unruly, abusive, or uncooperative and impairs the contractor's ability to furnish services to the member or other enrolled members
- The member is placed out of home, intermediate care facility for Individuals with intellectual disabilities (ICF/ IID)

Please notify the Humana Healthy Horizons Care Management Department if one or more of the situations listed above occur.

If members lose Medicaid eligibility, they also lose eligibility for Humana Healthy Horizons benefits.

Automatic renewal

If Humana Healthy Horizons members lose Medicaid eligibility, but become eligible again within two months, they are automatically re-enrolled in Humana Healthy Horizons in South Carolina and assigned to the same PCP, if possible. If you have questions about disenrollment reasons or procedures, please call Provider Services at **866-432-0001**.

Referrals for release due to ethical reasons

Humana Healthy Horizons 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 of treatments or procedures that they don't provide due to ethical reasons by submitting an email to the following email addresses:

- Medical providers: SCProviderupdates@humana.com
- Behavioral health providers: SCBHMedicaid@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 South Carolina to provide Medicaid services to beneficiaries. The provider also must be in Humana Healthy Horizons provider network.

Member Support Services and Benefits

Humana Healthy Horizons 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 can assist members who have questions or concerns about services, such as case management, disease management, non-emergency transportation coordination as well as regarding benefits.

Representatives are available by telephone at **866-432-0001** Monday through Friday, 8 a.m. to 6 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.

Member 24-hour nurse advice line

Members can call 24 hours a day, seven days a week, 365 days a year at **877-837-6952**. The toll-free number is listed on the member's ID Card. Members have unlimited access with an experienced staff of registered nurses to talk about symptoms or health questions.

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

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

Key features of this service include:

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

Behavioral health services

For mental or behavioral health services, members should call a contracted behavioral healthcare provider in their area. The behavioral healthcare provider can give the member a list of common problems with behavior health symptoms and talk to the member about how to recognize the problems. Members may call Humana Healthy Horizons in South Carolina's behavioral health toll-free number at **866-432-0001**.

Behavioral health crisis hotline

For members experiencing a behavioral health crisis, South Carolina has a statewide behavioral response network that operates 24 hours a day, seven days a week, year-round through their Community Crisis Response and Intervention (CCRI) Access Line. This service is designed to assist with de-escalating the crisis and provide linkage to ongoing treatment and other resources either in person, via phone or via telehealth communication software. CCRI also works directly with first responders who may be with the member at the time of the call. Once a member is directed to the most appropriate resource, Humana works with those providers to authorize services and ensure continuity of care for the member.

The number to contact the Community Crisis Response and Intervention (CCRI) Access Line is **833-364-2274**. Members may also contact the nationwide Suicide and Crisis Lifeline by calling or texting 988.

Emergency mental health conditions include:

- Those that create a danger to the member or others
- Those that render the member unable to carry out actions of daily life due to functional harm
- Those resulting in serious bodily harm that may cause death

Neonatal Intensive Care Unit (NICU) support for parents

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 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**, Monday through Friday, 8 a.m. to 6 p.m., Eastern time.

Interpreter services

Hospital and nonhospital providers are required to abide by federal and state regulations related to Sections

504 and 508 of the Rehabilitation Act, Americans with Disabilities Act (ADA), Executive Order 13166 and Section 1557 of the Affordable Care Act (ACA) in the provision of effective communication; this includes in-person or video-remote interpretation for deaf patients and over-the-phone interpretation with a minimum 150 languages available for non-English speakers.

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

Covered Services

Core benefits

It is the responsibility of the plan to notify SCDHHS as soon as they become aware of medical situations where SCDHHS medical policy isn't clearly defined. SCDHHS 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 SCDHHS website at www.scdhhs.gov.

Humana Healthy Horizons is required to provide its South Carolina 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 state Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in state statutes and regulations, the state Plan, and other state policy and procedures. While appropriate and necessary care must be provided, Humana Healthy Horizons is not bound by the current variety of service settings.

Covered services/core benefits:

- Abortions (coverage only when rape, incest or pregnancy endangering the woman's life is documented)
- Ambulance transportation
  - Transportation for out-of-state medical services
- Ancillary medical services
- Audiological services
  - Involves testing and evaluation of hearing-impaired children younger than 21 years of age whose hearing may or may not be improved with medication or surgical treatment.
  - This includes services related to hearing aid use.
  - Newborn hearing screenings are rendered to newborns in an inpatient hospital setting
- BabyNet
  - Administered by the South Carolina Department of Health and Human Services, BabyNet provides Early Intervention services for children from birth to age 3.
  - Services include supports and resources to assist and enhance the learning and development of infants and toddlers with disabilities and special needs.
- The full array of behavioral health services are set forth in the provider manuals listed on the SCDHHS website at www.scdhhs.gov.
- Chiropractic services
  - Limited to six visits per year for manual manipulation of the spine to correct a subluxation
- Disease management
- Communicable disease services
- Durable medical equipment (DME)
- EPSDT/Well-Child visits
- Emergency/post stabilization services
- Family planning services
- Home health services
- Hysterectomies
  - The member or representative, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing
  - The Consent for Sterilization form (DHHS Form HHS-687) must be completed (signed and dated) prior to the hysterectomy and obtained regardless of diagnosis or age
  - It is acceptable to sign the consent form after the surgery if it clearly states that the patient was informed prior to the surgery that she would be rendered incapable of reproduction
  - The consent form is not required if the individual is already sterile or in a life-threatening emergency situation that required a hysterectomy and prior acknowledgment was not possible. In these circumstances, a provider statement is required
  - Hysterectomies shall not be covered if performed solely for or if the primary purpose is to render an individual permanently incapable of reproducing
- Immunizations (vaccines) for children 18 years and younger are covered through the Vaccines for Children (VFC) Progam
- Immunizations (vaccines) for adults ages 19 years and older are covered as recommended by the Advisory Committee on Immunization Practices (ACIP)
- Independent laboratory and X-ray services
- Inpatient hospital services
- Institutional long-term care (LTC) facilities/nursing homes (NFs)
- Maternity services
- Outpatient services

- Physician services
- Pharmacy/prescription drugs
- Rehabilitative therapies for children – nonhospital-based
- Sterilization services
  - Sterilization shall mean any medical procedure, treatment or operation done for the purpose of rendering a member permanently incapable of reproducing
  - The member to be sterilized must voluntarily give informed consent on the approved consent for sterilization form (SCDHHS Form HHS-687) and:
    - at least 30 days, but no more than 180 days, must pass between the signing of the consent form and the date of the sterilization procedure
    - consent cannot be obtained while the patient is in the hospital for labor, childbirth, is seeking or obtaining an abortion or is under the influence of alcohol or other substances that may affect the patient's state of awareness
    - The member must be at least 21 years of age at the time consent is obtained
    - The member cannot be mentally incompetent
    - The member cannot be institutionalized
- Substance abuse
- Telehealth services
  - For medical and behavioral health services, virtual visits are available through select providers. Similar to using FaceTime® or Skype®, the member uses a webcam and a screen to talk to a licensed healthcare provider. These virtual visits are private and confidential.
- Transplant and transplant-related services
- Vision care
- Additional services

Emergency transportation

For emergency transportation services, call 911.

Member costs

Covered medical services are provided at no cost to the member. Humana Healthy Horizons has waived all copays, with the exception of pharmacy costs.

Excluded services

The services detailed below are those services that continue to be provided and reimbursed by the current Medicaid program and are consistent with the outline and definition of covered services in the Title XIX SC State Medicaid Plan. Payment for these services remain Medicaid fee-for-service. MCOs are responsible for the continuity of care for all Medicaid MCO members by ensuring appropriate service referrals are made for the Medicaid MCO member for excluded services.

Information relating to these excluded service programs may be accessed by Humana Healthy Horizons from SCDHHS to help coordinate services.
The following services are covered by South Carolina Medicaid fee-for-service:

- Medical (non-ambulance) transportation
- Broker-based transportation (routine nonemergency medical transportation)
- Dental services
- Targeted case management (TCM) services
- Home- and community-based waiver services
- Medicaid Adolescent Pregnancy Prevention Services (MAPPS) family planning
- Developmental evaluation services (DECs)
- Early Intervention Services

Under federal law, Medicaid does not receive federal matching funds for certain services. Some of these are optional services that the SCDHHS may elect to cover. Humana Healthy Horizons is not required to cover services that South Carolina Healthy Connections has elected not to cover.

Added benefits

Humana Healthy Horizons 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 South Carolina Plan and the South Carolina 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 administers the benefit in accordance with all applicable service standards pursuant to our contract, the South Carolina Medicaid State Plan and all Medicaid coverage and limitations handbooks.

Humana Healthy Horizons members have specific enhanced benefits:

Value Added Benefit	Details and Limitations
Baby and Me meals	Up to two pre-cooked home-delivered meals per day for 10 weeks for pregnant women who are high risk. Care manager approval required.
Breast pumps	Female members can receive one non-hospital grade breast pump every two years, or one rental of a hospital grade breast pump if your baby has an inpatient stay in a neonatal intensive care unit (NICU).
Convertible car seat and portable crib	Pregnant members are contacted once we are notified that the mom is expecting. During the call or through a call to customer service, pregnant moms can confirm if a car seat or crib are needed prior to delivery. Pregnant members who do not need the crib/car seat prior to delivery are asked to enroll and actively participate in our HumanaBeginnings® care management program and complete a prenatal comprehensive assessment and then choose between a crib or a car seat. After completion of the postpartum assessment, and one follow up call the member can have the second item (portable crib/car seat). Members who need the crib and car seat prior to delivery will receive the items and will also be contacted for a postpartum assessment along with a follow up call. This applies per infant, per birth.
Fresh produce box	Up to four boxes of in-season nutritious fresh fruits and vegetable annually. Member must be identified as food insecure or diabetic, suffers from heart failure, or hypertension. Care manager approval required.
GED testing	GED test preparation assistance for members 16 and older including a bilingual adviser, access to guidance and study materials, and unlimited use of practice tests. Test preparation assistance is provided virtually to allow maximum flexibility for members. Also includes test pass guarantee to provide members multiple attempts at passing the test. Members ages 16-18 need South Carolina Verification of School Withdrawal Form completed by the principal or attendance supervisor of the last school attended. The GED may be taken at age 19 or older without the South Carolina Verification of School Withdrawal form.
Haircuts for kids	One standard haircut for members in grades K-12 valued at $20, who upload a photo of their school registration form or school ID or class schedule, redemption period July 2024 through September 2024. Upload a photo of your child's school registration form or school ID or class schedule in the Go365® app.
Housing assistance	Up to $750 for members 18 and older per member per lifetime to assist with the following housing expenses: • Apartment rent or mortgage payment (late payment notice required) • Utility payment for electric, water, gas or internet (late payment notice required) • Trailer park and lot rent if this is your permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority Plan approval required. • Member must complete Health Risk Assessment (HRA) • Member must not live in a residential facility or nursing facility • Funds will not be paid directly to the member If the bill is in the spouse's name, a marriage certificate may be submitted as proof
Newborn circumcision	Covered from 29 days old through 12 months.

Value Added Benefit	Details and Limitations
Over-the-counter (OTC) pharmacy allowance	Up to $30 per quarter allowance enables members to purchase products that support common occurring conditions, including but not limited to: • Pain relivers • Diaper rash cream • Cough and cold relief medicine • First aid equipment that do not require prescriptions. Unused amounts do not roll over to the next quarter.
Post-discharge meals	Up to 14 home-delivered meals following discharge from an inpatient or residential facility. Limited to four discharges per year.
Smartphone services	One free smartphone through the Federal Lifeline Program, per household. Members who are younger than 18 need a parent or guardian to sign up. This benefit covers per lifetime: one phone, one charger, one set of instructions, unlimited talk, text and high-speed data, training for you and your caregiver at the first case manager orientation visit if you are enrolled in care management. Member must make one phone call or send one text message every month to keep benefit. Member may qualify for enhanced benefits through the Affordable Connectivity Program (ACP) that provides unlimited minutes, 10 GB hotspot and unlimited data. You can opt into this benefit by contacting SafeLink at **800-SAFELINK** or online at www.safelink.com/en/ACP11. Benefits are subject to change by the FCC under the Lifeline program.
Sports physical	One sports physical per year for members ages 6-18.
Tobacco cessation program	Tobacco cessation program focuses on tobacco and vaping cessation coaching for members aged 12 and older. The program has a six-month engagement for a total of eight coaching calls, but members have 12 months to complete the program if needed. Humana's tobacco and vaping cessation health coaching program offers support for both over the counter (OTC) and prescription nicotine replacement therapy (NRT).
Vision services – adult	Comprehensive vision exams every year (12 months) for members 21 and older. One set of eyeglasses (lenses and frames) or contacts every two years. * Luxury frames are not allowed.
Waived copay (medical only)	No copays for medical and behavioral health services for members 19 and older.
Weight management program	Weight management coaching program delivers weight management intervention for members who are 12 and older. After receiving physician clearance, members can complete six weight management coaching sessions with health coach; approximately one call per month for a period of six months.
Youth academic support	Members in grades K-12 can access online tutoring services for two hours per week.
Youth development and recreation	Members 18 and younger can receive reimbursement of up to $250 annually for participation in activities including: • YMCA • Boys and Girls Club programming • Swim lessons • Computer coding classes • Music lessons

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's receipt of the provider's claim for services rendered.

Humana Healthy Horizons recommends that all providers submit their claims on behalf of a member by the end of August 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 or 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
Breast cancer screening	Annual $25 reward for female members ages 40 and older who obtain a mammogram.
Cervical cancer screening	Annual $25 reward for female members ages 21 and older who obtain a pap smear.
Chlamydia screening	Annual $25 reward for female members who obtain a chlamydia screening when sexually active and as recommended by their healthcare provider.
Colorectal cancer screening	Annual $25 reward for members ages 45 and older who obtain a colorectal cancer screening as recommended by their PCP.
COVID-19 vaccine	Annual $25 reward for members ages 5 and older who upload a picture/file of their completed COVID-19 vaccine card, one per year. Members who were vaccinated prior to enrollment in a Humana plan may upload a vaccination card within 90 days of enrollment to receive the reward. New members that were not vaccinated prior to enrollment in a Humana plan have 90 days from completion of the vaccination to upload the vaccination card to receive the reward.
Diabetic retinal eye exam	Annual $25 reward for diabetic members ages 18 and older who complete a retinal eye exam.
Diabetic screening	Annual $25 reward for diabetic members ages 18 and older who obtain a screening from their PCP for HbA1c and blood pressure.
Digital onboarding	One-time $25 reward for downloading Humana's mobile Go365 application and completing the registration.
Flu vaccine	Annual $25 reward for members who receive an annual flu vaccine from their provider, pharmacy or self-reporting if they received a vaccine from another source.
Follow-up after high-intensity care for substance use disorder	$25 reward for members who received follow-up care within 30 days of an inpatient hospital discharge, residential treatment or detoxification visit for a diagnosis of substance use disorder.
Follow-up after hospitalization for mental illness	$25 reward for members who received follow-up care within 30 days after a hospital discharge for a diagnosis of select mental illness or intentional self-harm.
Health risk assessment (HRA) completion	One-time $25 reward for completing the health risk assessment.
HPV vaccine	One-time $25 reward for members ages 9-13 who receive two doses of the HPV vaccine between their 9th and 13th birthday.
Level of care video	Annual $10 reward for members ages 19 and older after watching a short educational video about when to access the emergency room.
Notification of pregnancy (NOP)	$25 reward when pregnant members notify Humana of pregnancy prior to delivery once per pregnancy.

Healthy Activity	Reward
Postpartum visit	$25 in rewards for all postpartum females who complete one postpartum visit within 7 to 84 days after delivery once per pregnancy.
Prenatal visit	Pregnant members can earn $10 per prenatal visit, up to 10 prenatal visits, for a total of up to $100 once per pregnancy.
Tobacco cessation program	Members ages 12 and older who enroll in the tobacco cessation program will have two opportunities to earn rewards: • $25 reward for completing two calls within 45 days of enrollment in the program • $25 rewards for completing the full program
Weight management program	Members ages 12 and older who enroll in the weight management program will have two opportunities to earn rewards: • $15 reward for completing a wellbeing check-up • $15 reward for completing the program
Well-child visit (0-15 months)	Up to $120 in reward for members who complete routine well-child visits. Members can receive $20 in rewards per visit with a six-visit limit.
Well-child visits (16-30 months)	Up to $30 in rewards for members who complete routine well-child visits. Members can receive $15 per visit with a two-visit limit.
Wellness visits	Annual $25 reward for members ages 3 and older for completing an annual wellness visit

Out-of-network care when services are unavailable

Humana Healthy Horizons will arrange 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. Humana Healthy Horizons coordinates 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.

Referrals

Humana Healthy Horizons members may see any participating network provider, including specialists and inpatient hospitals. Humana Healthy Horizons 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 are not exhausted.

Second medical opinions

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.

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

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

Release due to ethical reasons

Providers are not required to perform treatments or procedures contrary to the provider's conscience, religious beliefs or ethical principles, in accordance with 45 C.F.R 88. For more information see the Referrals for Release due to Ethical Reasons section in this manual.

Behavioral health and substance-use services under Humana Healthy Horizons in South Carolina

Behavioral health and substance-use services are covered for Humana Healthy Horizons members. Understanding that both behavioral and physical health equally affect a person's wellness, we use a holistic treatment approach to address behavioral health and substance use.

Humana Healthy Horizons provides a comprehensive range of basic and specialized behavioral health services. Basic behavioral health services are provided through primary care, including, but not limited to, mental health and substance-use screenings, prevention, early intervention, medication management, treatment and referral to specialty services. The professional and outpatient facility charges associated with Medicaid-covered behavioral health services are included in Humana Healthy Horizons' covered responsibilities. Humana Healthy Horizons reimburses health care professionals/providers for most outpatient behavioral health services without prior authorization. Providers should refer to the Prior Authorization List at Humana.com/PAL to obtain list of services requiring prior authorization.

Specialized behavioral health services constitute several services, including but not limited to:

- Inpatient hospitalization for behavioral health services
- Outpatient and residential substance use disorder services in accordance with the American Society of Addiction Medicine (ASAM) levels of care
- Medication assisted treatment, including buprenorphine and naltrexone, available in multiple settings including residential
- Crisis management: Services provided to an individual experiencing a psychiatric crisis designed to interrupt and/or ameliorate a crisis experience through a preliminary assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services
- Applied behavioral analysis therapy (younger than 21): The design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior
- Licensed practitioner outpatient therapy which includes, but is not limited to:

• Individual, family, group and multi-family group psychotherapy	• Assessment and screening
• Psychological evaluation and testing	• Medication management
• Psychological evaluation and treatment	• Medication administration
• Individual therapy with medical evaluation, management and case consultation	• Service plan development

- Community Support Services, including the following (prior authorization required)
  - Psychosocial rehabilitation services (PRS)
  - Behavior modification (B-MOD) – (available up to age 21)
  - Family support (FS) (available for families of children up to age 21)
  - Therapeutic childcare (TCC) (available up to age 6)
  - Community integration services (CIS) (available to adults with Severe and Persistent Mental Illness (SPMI)/Substance Use Disorder (SUD)
  - Peer Support Services (PSS) (rendered by the Department of Mental Health (DMH) and Department of Alcohol and Other Drug Abuse Services [DAODAS] Providers only.)

Providers, members or other responsible parties can contact Humana Healthy Horizons at **866-432-0001** to verify available behavioral health and substance-use benefits and seek guidance in obtaining behavioral health and substance-use services.

Our network focuses on improving member health through evidence-based practices. The goal: We want to provide the level of care needed by the member within the least restrictive setting.

Behavioral health prior authorization

For behavioral health services that require prior authorization, requests may be submitted via fax, email, phone or via the Availity Essentials provider portal.

- Online: through Availity.com
- Phone: **866-432-0001**
- Email: CorporateMedicaidCIT@humana.com
- Fax: 833-441-0950

Prior authorization request forms are available on our provider website at South Carolina Medicaid Provider Prior Authorization – Humana, or by contacting the Behavioral Health department and requesting they fax the necessary forms. If a form is required to be completed for a particular service, it can be uploaded and submitted with the prior authorization request within the Availity Essentials provider portal. For questions regarding prior authorization requirements or to obtain authorization, call **866-432-0001**.

Humana Healthy Horizons continues to coordinate the referral of our members for services that are outside of the required core benefits and continue to be provided by enrolled Medicaid health care professionals/ providers. These services include but are not limited to developmental evaluation centers, intensive family treatment services, adolescent treatment facilities,

inpatient psychiatric hospital, private residential treatment facility services, and waiver programs.

Rehabilitative behavioral health services (RBHS)

Humana Healthy Horizons is responsible for the rehabilitative behavioral health service (RBHS) array provided by DMH, private RBHS providers, and school districts. RBHS are medical or remedial services that are recommended by a physician or other licensed practitioner of the healing arts for maximum reduction of physical or mental disability and restoration of a member to their best possible functional level.

RBHS includes the following categories:

- Assertive Community Treatment (ACT) services — an intensive nonresidential treatment and rehabilitative mental health service that provides a single, fixed point of responsibility for treatment, rehabilitation, and support needs for members with severe mental illness (SMI) who require a higher level of community care and have not been well supported in lower level-of-care options.
- Behavior modification — Used to provide the member with redirection and modeling of appropriate behaviors to enhance function in the home and/or community.
- Psychosocial rehabilitative services — Intended as a skill-building service for members, not a form of psychotherapy or counseling.
- Family support services — Utilized to enable the family or caregiver to engage in the treatment team for a member and/or improve their ability to care for the member.
- Community integration services — Targeted treatment service for adults ages 18 years and older with serious and persistent mental illness.
- Therapeutic child care (TCC) — Targeted treatment services for children younger than age 6 who experienced trauma, neglect, and abuse and are in need of early intervention

RBHS provided by licensed or certified clinicians must follow supervision requirements as required by South Carolina state law. Please see RBHS provider manual for supervision requirements. Case supervision and consultation does not negate training requirements. The frequency of supervision should be evaluated on a case-by-case basis.

School-based mental health initiative

In accordance with the SCDHHS School-based Mental Health Initiative, effective July 1, 2022: RBHS are allowed to be delivered in school settings by Humana Healthy Horizons master's level behavioral health providers who are contracted by the school district for members younger than 21 years of age. South Carolina school districts are free to choose to:

- Continue to utilize the South Carolina DMH by contracting with DMH, who then bill Humana Healthy Horizons.
- Hire their own counselors and bill Humana Healthy Horizons directly.
- Contract with a private provider who bill Humana Healthy Horizons directly
- Use a combination of these delivery methods to meet the needs of the children in their district.

Autism spectrum disorder (ASD)

Humana Healthy Horizons also provides ASD coverage for members younger than 21 years. This benefit includes ASD services rendered by board-certified behavior analysts (BCBA), board-certified assistant behavior analysts (BCaBA), and registered behavioral technicians (RBT), as well as by licensed independent practitioners (LIPs) who are approved by South Carolina Department of Disabilities and Special Needs (SCDDSN) to provide evidence-based treatment (an ABA alternative therapy modality)

Acute inpatient psychiatric facilities for behavioral health and substance use

The Humana Healthy Horizons contract with SCDHHS includes coverage of acute inpatient services provided in free-standing psychiatric facilities. Humana Healthy Horizons adheres to guidelines as outlined in the SCDHHS Psychiatric Hospital Services Provider Manual. Prior authorization is required for all acute inpatient admissions. Acute inpatient services provided in free-standing psychiatric facilities include behavioral health, alcohol and drug detoxification services. Additionally, the following is a Healthcare Effectiveness Data and Information Set (HEDIS) follow-up health measure:

- Post-discharge follow up: an outpatient visit following hospitalization for a mental health disorder; with a mental health practitioner for adults and children 6 years and older within seven calendar days

A SCDHHS Certification of Need (CON) for Psychiatric Hospital Services must be completed for all members admitted for acute inpatient treatment services in a free-standing psychiatric hospital. This form also can be found in the forms section of the Psychiatric Hospital Services Manual Forms.pdf (scdhhs.gov) The Code of Federal Regulations, 42 CFR 441.151, states that inpatient psychiatric services must be certified as necessary, in writing, for the setting in which the services are provided in accordance with CFR 441.152.

Residential substance abuse treatment

Humana Healthy Horizons covers residential substance abuse treatment. residential substance abuse treatment services include an array of services consistent with the member's assessed treatment needs, with a rehabilitative and recovery focus designed to promote coping skills and manage substance-use symptoms and behaviors in a residential setting. Prior authorization is required for these services and members must be assessed to establish medical necessity for the treatment of services.

Psychiatric residential treatment services

Psychiatric residential treatment services (PRTF) level of care is reserved for beneficiaries whose immediate treatment needs require a structured 24-hour inpatient residential setting that provides all services (including educational) onsite. PRTFs are facilities, other than a hospital, that provide psychiatric services to children younger than age 21 in an inpatient setting. PRTFs provide inpatient psychiatric services to children younger than 21 who do not need acute inpatient psychiatric care but need a structured environment with intensive treatment services.

To receive reimbursement for these services, providers must meet the facility requirements in the Psychiatric Hospital Services Manual. Prior authorization along with completed Certificate of Need form is required.

Opioid treatment programs (OTP)

Humana Healthy Horizons covers programs that provide evidence-based medication-assisted treatment (MAT) for members with opioid use disorder (OUD). With the exception of continuity of care, coverage must be provided by providers who are contracted with Humana Healthy Horizons and enrolled with SCDHHS. For members being treated by an out-of-network provider, Humana Healthy Horizons Utilization Management works with providers and the member to transition to an in-network provider. Prior authorization is not required for OTP services. However, members must meet certain requirements to qualify for treatment and seek treatment from an in-network provider. Consult the SCDHHS Clinic Services Provider Manual, for a list of these requirements.

Behavioral Health Screening and Evaluation

Humana Healthy Horizons requires that network PCPs receive the following training:

- Screening and evaluation procedures for identification and treatment of suspected behavioral health problems and disorders
- Application of clinically appropriate behavioral health services, screening techniques, clinical coordination and quality of care within the scope of their practices

Continuation of Behavioral Health Treatment

Humana Healthy Horizons requires that an outpatient follow-up appointment be scheduled prior to a member's discharge from an in-patient behavioral health treatment facility. The appointment must occur within seven days of the discharge date. Behavioral healthcare providers are expected to contact patients within 24 hours of a missed appointment to reschedule.

Early and Periodic Screening and Diagnosis and Treatment (EPSDT)

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

EPSDT benefits are available at no cost to members.

EPSDT preventive services

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

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

Covered services EPSDT preventive exam components include:

- Comprehensive health and development history
- Comprehensive unclothed physical examination
- Laboratory tests, including (where indicated) blood-lead level screening/testing, anemia test using hematocrit or hemoglobin determinations, sickle-cell test, complete urinalysis, testing for sexually transmitted diseases, tuberculin test and pelvic examination
- Developmental screening/surveillance, including autism screening
- Sensory screenings and referrals for vision and hearing
- Nutritional assessment, including body mass index (BMI) and blood pressure
- Dental screenings and referrals to a dentist, as indicated

(dental referrals are recommended to begin during a child's first year of life and are required at 2 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 1, 2, 5 and 6 months

EPSDT special services

Under the EPSDT benefit, Medicaid provides comprehensive coverage for all services 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 South Carolina 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 South Carolina 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 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. Additionally, SCDHHS developed an oral health section of the Medical Periodicity Schedule for oral health services to be performed by providers. More details are available at https://www.scdhhs.gov/press-release/medicaid-periodicity-schedule.

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)	

Oral health and dental services

Following the recommendations of the American Academy of Pediatric Dentistry, SCDHHS developed a dental periodicity schedule. More information is available at msp.scdhhs.gov/epsdt/site-page/periodicity-schedule.

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.

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 endorses the same recommended childhood immunization schedule recommended by the Centers for Disease Control and Prevention (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.

The South Carolina Department of Health and Environmental Control offers immunization programs for eligible adults and children.

Additional information on the Vaccines for Children Program, South Carolina State Vaccine Program, and Adult Vaccine Program can be found at scdhec.gov/health/vaccinations.

SCDHHS continues to reimburse for the administration of age-appropriate vaccinations provided to children when the vaccine is obtained through the VFC program. For accuracy and program compliance, SCDHHS requires that claims for vaccinations include the Current Procedural Terminology code (CPT) for the vaccine product that is administered, however only the administration code is reimbursable.

Pharmacy

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

Humana Healthy Horizons adheres to state and federal regulations on medication coverage for our members.

Drug coverage

Our Pharmacy and Therapeutics Committee (P&T), which consists of practicing physicians and pharmacists across clinical specialties, identifies all covered legend and over-the-counter drugs, as well as certain supplies and select vitamin and mineral products available under the pharmacy benefit. The committee evaluates pharmaceutical products using industry proven clinical resources, including FDA approval information, peer-reviewed medical literature, evidence-based effectiveness studies, and clinical practice guidelines (CPG), to create and evolve evidence-based comprehensive drug lists (CDLs) that produce a positive, cost-effective outcome.

Utilization management (UM)

The CDL identifies covered drugs and associated drug utilization management requirements, such as prior authorization, quantity limits, step therapy, etc.

- Prior authorization (PA): the medication must be reviewed using a criteria-based approval process prior to coverage decision
- Step therapy: the member is required to utilize medications commonly considered first-line before using medications considered second- or third-line.
- Drug safety limits: facilitate the appropriate, approved label use of various classes of medications, e.g. drug-drug interaction, opioid limits, and therapeutic duplication.
- Generic substitution- generic drugs should be dispensed when available. If using a particular brand name is determined to be medically necessary, PA must be obtained.

72-Hour Emergency Supply

For claims where a pharmacist is unable to fill a medication that denies at point of sale for error codes requiring a prior authorization, Humana Pharmacy Solutions will allow the pharmacists to fill an emergency 72-hour supply based on the pharmacist's clinical judgement. This includes unbreakable package items as well, example: Albuterol Inhalers or Insulin.

1. When a claim denies at point of sale due to requiring a prior authorization, the pharmacist can enter a 72-hour emergency fill (if the pharmacist believes the patient's health would be in serious jeopardy) by using submission clarification code (SCC) 65 that is provided in the denial message.
2. Once the pharmacist submits the claim using SCC 65, the system will over-ride the prior authorization denial and allow a 3-day supply to be dispensed.
3. The claims processing system will not count emergency 72-hour supply fills against a member's monthly script limit when processing claims.

Coverage limitations

The following is a list of non-covered, i.e., excluded from the Medicaid benefit drugs and/or categories:

- Agents used for anorexia, weight gain or weight loss, some exceptions may apply
- Agents used to promote fertility
- Agents used for cosmetic purposes or hair growth, some exceptions may apply
- Drugs for the treatment of erectile dysfunction
- Drug Efficacy Study Implementation (DESI) drugs or drugs determined to be identical, similar or related
- Investigational or experimental drugs
- Agents prescribed for any indication that is not medically accepted

CDL updates

South Carolina Department of Health and Human Services (SCDHHS) may add or remove drugs on the CDL throughout the year. We also may change our utilization management requirements for covered drugs. Examples include:

- Elect to require or not require prior authorization
- Elect to change the quantity limits
- Add or change step therapy restrictions
- Update, add guidance or implement new clinical guidelines for a drug from the Food and Drug Administration (FDA)

- Add a generic drug new to the market

All negative changes are posted to our website at least 30 days prior to implementation. Please visit- South Carolina Medicaid Provider Documents - Humana for updates.

Please review the current formulary prior to writing a prescription to determine if a drug is covered. The CDLs are updated regularly; to view the current CDL, go to Humana.com/DrugLists. To view current medical and pharmacy coverage policies, please visit Medical and Pharmacy Coverage Policies at Humana.com.

Medications administered in the provider setting

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

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

Coverage determinations and exceptions

You may request coverage determinations, such as medication prior authorization, step therapy, quantity limits and formulary exceptions, via the following methods:

- Obtain forms at Humana.com/PA
- Submit requests electronically by visiting Covermymeds.com/epa/Humana
- Submit requests by fax to 877-486-2621
- Call Humana Clinical Pharmacy Review (HCPR) at 800-555-CLIN (800-555-2546).

Coverage determination decisions are reviewed based on medical necessity; decisions are communicated within 24 hours after the request is received from the prescriber.

Medication appeals

If we deny the member's coverage determination or formulary exception, you can ask for a review of our decision by making an appeal on behalf of the member. Please review the Grievances & Appeals section of this manual for details on how to submit appeals.

If you prefer to have a discussion with one of our pharmacists or regional medical directors, you may initiate a peer-to-peer (P2P) request by calling **844-330-7734** and leaving a detailed message, including:

- Name of physician requesting the P2P discussion and contact information (including a call back number)
- Date and times available - (must provide two one hour timeframes within the next two business days, example: Monday, Jan. 6, 2023, between 3 and 5pm Eastern time)

Please note: The P2P discussion is not considered part of the appeal process and depending on the outcome, you may still request a formal appeal with written authorization from the member if necessary.

Electronic prescribing

Through our participation in the SureScripts network, our pharmacy benefit manager (PBM) eligibility, formulary and member medication history are available through every major electronic health record (EHR) or e-prescribing (eRx) vendor, including Allscripts, Epic, Cerner, athenahealth, and DrFirst. Prescribers with EHR or eRx can view real-time clinical information about the formulary, safety alert messaging and prior authorization requirements.

Network pharmacies

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

Members have access to Humana's mail-order pharmacy, CenterWell Pharmacy®, and other available mail-order options that can be found on Pharmacy finder which sends medications directly to their home. If a specialty medication is required, our specialty pharmacy, CenterWell Specialty Pharmacy®, may be able to assist. For additional information about these options please visit:

CenterWellPharmacy.com or call:

- CenterWell Pharmacy: **800-379-0092**, Monday through Friday 8 a.m. to 11 p.m., Eastern time. Saturday 8 a.m. to 6:30 p.m., Eastern time.
- CenterWell Specialty Pharmacy: **800-486-2668** (TTY: 711), Monday through Friday 8 a.m. to 11 p.m., Eastern time. Saturday, 8 a.m. to 6 p.m., Eastern time.

Over-the-counter (OTC) Health and Wellness

Humana Health Horizon members have an expanded pharmacy benefit, which provides a $30/ quarter allowance to spend on OTC health and wellness items. Unused OTC allowances do not roll over to the next quarter. These OTCs and products will be sent by FedEx, UPS or the U.S. Postal Service within 10 to14 working days after the order is made. There is no charge to the member for shipping. You can find an order form and the full list of OTC health and wellness items available for members at Humana.com.

If you have questions about this mail-order service, please call: CenterWell Pharmacy at **855-211-8370** (TTY: 711). Hours of operation are, Monday through Friday 8 a.m. to 11 p.m., Eastern time. Saturday 8 a.m. to 6:30 p.m., Eastern time.

Pharmacy Lock-in Program

The Lock-in Program is designed for individuals enrolled in Humana Healthy Horizons 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. Humana Healthy Horizons members who meet the program criteria are locked into one specific pharmacy location.

The Lock-in Program is required by SCDHHS.

Humana Healthy Horizons monitors claim activity for signs of misuse or abuse in accordance with state and federal laws. Quarterly reports are generated by the Department of Program Integrity (PI) reviewing all Medicaid member's claims for a six-month period. The report is reviewed for 20 different weighted criteria as established by PI. The member is assigned a score and based on criteria met, is identified for the State Pharmacy Lock-in Program (SPLIP). Members identified for the lock-in program receive written notification from Humana Healthy Horizons, along with the designated lock-in pharmacy's information and the member's right to appeal the plan's decision.

Members are initially locked-in for a total of two years, during which the member can request a change from their designated lock-in pharmacy upon approval. Members will be notified as to whether the request for the change has been approved or denied.

If a member should transfer between Managed Care Organizations (MCOs), the member will continue to be in the SPLIP program continuously, regardless of transfers between MCOs or Medicaid eligibility.

Following the member's two year enrollment, the member's future claims are monitored. If the 20 criteria report identifies the member with a score, the member will be re-enrolled in the SLPIP.

Excluded from enrollment in the Lock-in Program are:

- Members in hospice, with a date of death or no longer Medicaid eligible
- Are younger than 16
- Members currently in a lock–in program
- Members with sickle cell disease (ICD10 codes D57.00 through D57.1, D57.20 through D57.219 and D57.4 through D57.819)

Utilization Management (UM)

Utilization management helps maintain the quality and appropriateness of healthcare services provided to Humana Healthy Horizons members. Utilization review determinations are based on medical necessity, appropriateness of care and service and existence of coverage. Humana Healthy Horizons does not reward providers or our staff for denying coverage or services. There are no financial incentives for Humana Healthy Horizons staff to encourage decisions that result in underutilization.

Humana Healthy Horizons 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 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 on the basis of criteria applied under the Humana Healthy Horizons plan, and applicable regulations, including medical necessity. Humana Healthy Horizons places 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.

Criteria

Humana Healthy Horizons currently uses the following to make both administrative and medical necessity determinations as appropriate for inpatient acute, behavioral health, outpatient, rehabilitation and skilled nursing facility admissions:

- South Carolina state regulations
- Member benefits and member handbook
- Humana coverage guidelines

- MCG and the American Society of Addiction Medicine (ASAM) criteria, which are nationally recognized, evidence-based clinical UM guidelines

These guidelines are intended to allow Humana Healthy Horizons 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 medical care; they are to provide guidance to our physician providers related to medically appropriate care and treatment.

Humana defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services in accordance with 42 CFR 438.210 (a)(5). This federal regulation defines medically necessary services as those services utilized in the state Medicaid program, including quantitative and nonquantitative treatment limits, as indicated in state statutes and regulations, the state plan, and other state policy and procedures. Humana also has policy statements developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria for approval, the case is forwarded to a medical director for further review and determination. During the review process, the medical director may elect to discuss or consult with an external board-certified same-specialty physician from an NCQA-certified independent review organization. Humana's medical director utilizes the plan's criteria, their personal medical expertise, and external resources, to determine if the request for services will be approved or denied. All adverse benefit determinations are communicated in writing to the member and requesting health care provider. This communication provides the reason(s) for denial and how to initiate the appeal process. At any time, the requesting health care provider may contact Humana Healthy Horizons to request a copy of the criteria used to make the final determination. Additionally, Humana's medical directors are available to discuss medical necessity determinations with the requesting health care provider. Health care providers may contact the utilization management centralized intake team to request a peer-to-peer discussion within five calendar days of the adverse benefit determination. To request a peer-to-peer discussion, please call **866-432-0001 (TTY: 711)**, Monday through Friday, from 8 a.m. to 8 p.m., Eastern time, and select "Authorization and Provider" when prompted.

Staff access

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

- Medical health inquiries: Call **866-432-0001** or email SCMCDUM@humana.com
- Behavioral health inquiries: Call **866-432-0001** or email SCMCDUM_BH@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 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 first priority. Physician reviewers from Humana are available to discuss individual cases with attending physicians on request.

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

- Medical health inquiries: Call **866-432-0001** or email SCMCDUM@humana.com
- Behavioral health inquiries: Call **866-432-0001** or email SCMCDUM_BH@humana.com

If you would like to request a peer-to-peer discussion on an adverse determination with a Humana physician reviewer, please contact our Clinical Intake Team at **866-432-0001** within five business days of the determination.

Claims

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

Please note: failure to include ICD-10 codes on electronic or paper claims results in claim denial.

Claim submissions

Claims, including corrected claims, must be submitted within one year from the date of service or discharge.

We do not pay claims with incomplete, incorrect or unclear information. Providers have 30 calendar days from the claim processing date found on the explanation of remittance.

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

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

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

- Patient (member) name
- Patient address
- Insured's ID number: Be sure to provide the complete Humana Healthy Horizons in South Carolina member ID for the patient
- Patient's birth date: Always include the member's date of birth so we can identify the correct member in case we have more than one member with the same name
- 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 of this manual.
- 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 SCDHHS Master Provider List (MPL)
- Billing and rendering addresses that match the SCDHHS 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.

Claim Dispute Process

Providers can submit claim disputes if they disagree with the outcome of the claim. Claim dispute submissions must be received by Humana Healthy Horizons within 30 calendar days of the original claim date of adjudication.

For more details regarding this process, see the Provider Disputes section of this manual.

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

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

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

With EFT, your Humana Healthy Horizons claim payments are deposited directly in the bank account(s) of your choice. You also are enrolled for our ERA, which replaces the paper version of your explanation of remittance.

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

EFT/ERA Enrollment through Humana Healthy Horizons in South Carolina

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

Physicians and other healthcare providers can use Humana's ERA/EFT enrollment tool on Availity Essentials to enroll.

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

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

EFT payment transactions are reported with file format CCD+, which is the recommended industry standard for EFT payments. The CCD+ format is a National Automated

Clearing House Association (ACH) corporate payment format with a single, 80-character addendum record capability. The addendum record is used by the originator to provide additional information about the payment to the recipient. This format is also referenced in the ERA (835 data file). Contact your financial institution if you would like to receive this information.

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

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

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

Submitting Electronic Transactions

Provider portal: Availity Essentials

Availity Essentials

This secure provider portal offers convenient self-service tools for working online with multiple payers, including Humana Healthy Horizons. Available features include:

- Eligibility and benefits lookup
- Member summary access
- Referrals and authorizations submission and review
- Claim status lookup
- Claim submission
- Remittance advice access
- Claim appeals/disputes submission and management
- Medical records submission and management
- Overpayment management
- ERA/EFT enrollment and management

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. Humana Healthy Horizons currently accepts electronic claims from South Carolina providers through the clearinghouses listed below. Please contact the clearinghouse of your choice to begin electronic claim submission.

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

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

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

Availity	Availity.com	**800-282-4548**
Trizetto	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**

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:

- 837P / 837I Claims encounters
- 835 Electronic remittance advice
- 276/277 Claims status inquiry
- 270/271 Eligibility
- 278 Prior-authorization requests
- 834 Enrollment
- NCPDP
- Provider Type to Taxonomy Crosswalk

Procedure and diagnosis codes

Federal law establishes various standards for all covered transactions under HIPAA, including electronic medical claims. Those standards currently include these code sets:

- Healthcare Common Procedure Coding System (HCPCS), which includes
  - Current Procedural Terminology (CPT®) codes, available from the American Medical Association (http://AMA-assn.org/practice-management/cpt)

- HCPCS Level II codes, available from CMS at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update
- National Drug Codes (NDC), available from the U.S. Food and Drug Administration at https://www.fda.gov/drugs/drug-approvals-and-databases/national-drug-code-directory
- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), available from the Centers for Disease Control and Prevention at https://www.cdc.gov/nchs/icd/Comprehensive-Listing-of-ICD-10-CM-Files.htm
- International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS), available from CMS at https://www.cms.gov/medicare/coding/icd10

Code sets are also typically available, in various media, from vendors licensed to publish them.

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

Unlisted CPT/HCPCS codes

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

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

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

NPI, TIN or Tax ID and Taxonomy

Your NPI and Tax ID are required on all claims, in addition to your provider taxonomy and specialty type codes (e.g., federally qualified health center, rural health center and/or primary care center) using the required claim type format (CMS-1500, UB-04 or Dental ADA) for the services rendered.

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

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

- Federally qualified health centers, provider type 31 with a specialty code 080
- Rural health centers, provider type 35

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

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

If your NPI and taxonomy codes change, please ensure you update your taxonomy information with Humana Healthy Horizons and the SCDHHS MPL. Please contact Humana Healthy Horizons Provider Services at **866-432-0001**, or your provider agreement representative, to update your demographic information. Please mail your changes to:
Humana Provider Correspondence
P.O. Box 14601
Lexington, KY 40512-4601

Location of provider NPI, TIN and member ID number

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

On 5010 (837P) professional claims:
The provider NPI should be in the following location:

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

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

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

On 5010 (837I) Institutional Claims:

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

The billing provider 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 South Carolina Member ID number should go on:
- 2010BA Loop = Subscriber name
- NM109 = Member ID number

Paper Claim Submissions

For the most efficient processing of your claims, Humana Healthy Horizons recommends all claims be submitted electronically. If you submit paper claims, please use one of the following claim forms:
- CMS-1500, formerly HCFA 1500 form — AMA universal claim form also known as the National Standard Format (NSF)
- CMS-1450 (UB-04), formerly UB92 form, for facilities

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

Detailed instructions for completing forms are available at the following websites:
- CMS-1500 Form Instructions: Nucc.org
- UB-04 Form Instructions: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15_1450

Please mail all paper claim forms to Humana Healthy Horizons at the following address:
Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

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

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

Instructions for NDC on paper claims

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

Tips for submitting paper claims

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

Out-of-network Claims for Non-Emergency Services

Humana Healthy Horizons established guidelines for payments to out-of-network providers for preauthorized medically necessary services. These services are reimbursed, with prior authorization, at 100% of the South Carolina Medicaid fee schedule.

Claim Processing Guidelines

Timely filing

- Providers have one year from the date of service or discharge to submit a claim. If the claim is submitted after the applicable timely filing term, the claim is denied for timely filing.
- If a member has Medicare and Humana Healthy Horizons is their secondary coverage, the provider may submit for secondary payment within two years from the date of service or within six months from Medicare adjudication date.
- If a member has other insurance and Humana Healthy Horizons is secondary, it is recommended that the provider submit for secondary payment within 30 days from the other insurance payment date.

Coordination of Benefits

- COB requires a copy of the appropriate remittance statement from the primary carrier payment:
  - Electronic claims - primary carrier's payment information
  - Paper claims – EOB from primary carrier
- Medicare COB claims - Appropriate remittance statement must be received within two years from the date of service or within six months from Medicare adjudication.
- Non- Medicare primary payer – Appropriate remittance statement must be received within two years from date of service or six months from the date of the primary payer's Explanation of Benefits (EOB) or Remittance Advice (RA).
- If a claim is denied for COB information needed, the provider must submit the appropriate Remittance Statement from the primary payer within the COB claims timely filing period.

Newborn claims

- All claims for newborns must be submitted using the newborn's Humana Healthy Horizons in South Carolina ID number and South Carolina Medicaid ID number. Newborn infants are deemed eligible for Medicaid and automatically enrolled by the birthing hospital with Humana Healthy Horizons, if sent within three months of birth. This coverage for the mother continues for 12 months after the baby's birth. The infant is covered up to age one. Do not submit newborn claims using the mother's identification numbers; the claim is denied. Claims for newborns must include birth weight.

Home Health Services and Electronic Visit Verification (EVV) systems

In compliance with the 21st Century CURES Act, providers are required to utilize Electronic Visit Verification (EVV) to electronically monitor, track and confirm services provided in the home setting. Providers must ensure that services are provided as specified in the health plan enrollee's care plan; in accordance with the established schedule, including the amount, frequency, duration, and scope of each service; that services are provided in a timely manner; and must work with the Humana to identify and immediately address service gaps, including, but not limited to late and missed visits.

Other claim requirements

- Abortion, sterilization and hysterectomy procedure and initial hospice claims submissions must have consent forms attached. The forms can be found in the "Forms" tab in the provider manuals for Hospital and Physician Services. (scdhhs.gov)
- Claims indicating that a member's diagnosis was caused by the member's employment are not paid. The provider is advised to submit the charges to Workers' Compensation for reimbursement.

Claims Compliance Standards

Humana Healthy Horizons ensures their compliance target and turnaround times for electronic claims to be paid/ denied comply with the following time frames:

- The managed care plan pays 90% of all clean claims submitted from providers, including Indian healthcare providers, within 30 calendar days from the date of receipt.
- The managed care plan pays 99% of all clean claims from providers, including Indian healthcare providers, within 90 calendar days of the date of receipt.

Humana Healthy Horizons will adhere to the following guidelines regarding acknowledgement and payment of all submitted claims for services:

- Issue payment for a clean, paper claim within 40 business days following the later of receipt of the claim or the date on which Humana Healthy Horizons is in receipt of all information needed and in a format required for the claim to constitute a clean claim and is in receipt of all documentation requested:
  - to determine that such claim does not contain any material defect, error, or impropriety; or
  - to make a payment determination.
- Issue payment for a clean, electronic claim within 20 business days following the later of receipt of the claim or the date on which Humana Healthy Horizons is in receipt of all information needed and in a format required for the claim to constitute a clean claim and is in receipt of all documentation requested:
  - to determine that such claim does not contain any material defect, error, or impropriety; or
  - to make a payment determination.

Humana Healthy Horizons affixes to or on paper claims, or otherwise maintain a system for determining, the date claims are received. Electronic claim acknowledgement is sent electronically to either the provider or the provider's designated vendor for the exchange of electronic health care transactions. The acknowledgement must identify the date claims are received. If there is any defect, error, or impropriety in a claim that prevents the claim from entering the adjudication system, Humana Healthy Horizons provides notice of the defect or error either to the provider or the provider's designated vendor for the exchange of electronic health care transactions within 20 business days of the submission of the claim if it was submitted electronically or within 40 business days of the claim if it was submitted via paper. Nothing contained in this section is intended or may be construed to alter Humana Healthy Horizons' ability to request clinical information reasonably necessary for the proper adjudication of the claim or for the purpose of investigating fraudulent or abusive billing practices.

Crossover Claims

Humana Healthy Horizons must receive the Medicare EOB with all crossover claims. The claims adjuster reviews to ensure that all fields are completed on the EOB and determines the amount that should be paid out.

Crossover claims should not be denied if received within two years or six months from Medicare adjudication.

Claim Status

You can track the progress of submitted claims at any time through Availity Essentials, our provider portal at Availity.com. Claim status is updated daily and the portal 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

Claims payments by Humana Healthy Horizons to providers are accompanied by an itemized accounting of the individual claims in the payment that includes, but is 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 entity.

Humana Healthy Horizons extends each provider the opportunity for a meeting with a Humana Healthy Horizons representative if it believes a clean claim remains unpaid, in violation of the South Carolina Code of Laws. Additionally, the same opportunity is extended to providers if a claim remains unpaid for more than 45 days after the date the claim was received by Humana Healthy Horizons.

Code Editing and Payment Policies

Humana processes accurate and complete provider claims in accordance with Humana's normal claims processing procedures, including, but not limited to, claims processing edits and claims payment policies, and applicable state and/or federal laws, rules and regulations. See the providers' section of Humana.com to access a summary of changes to claims processing procedures; this summary of changes to claims processing procedures is not intended to be an exhaustive list.

Such claims processing procedures include review of the interaction of various factors. The result of Humana's claims processing procedures is dependent on the factors reported on each claim. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures, but examples of the most commonly used factors include:

- The complexity of a service
- Whether a service is one of multiple same-day services such that the cost of the service to the provider is less than if the service had been provided on a different day. For example:
  - Two or more surgeries performed the same day
  - Two or more endoscopic procedures performed the same day
  - Two or more therapy services performed the same day
- Whether a co-surgeon, assistant surgeon, surgical assistant or any other provider billing independently is involved
- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together
- Whether the service is reasonably expected to be provided for the diagnosis reported
- Whether a service was performed specifically for the enrollee
- Whether services can be billed as a complete set of services under one billing code

Humana Healthy Horizons develops claims processing procedures in our sole discretion based on our review of correct coding initiatives, national benchmarks, industry standards, and industry sources that include the following, including any successors of the same:

- SCDHHS regulations, manuals and other related guidance

- Federal and state laws, rules and regulations, including instructions published in the Federal Register
- National Uniform Billing Committee (NUBC) guidance, including the UB-04 Data Specifications Manual
- American Medical Association's (AMA) CPT and associated AMA publications and services
- CMS' Healthcare Common Procedure Coding System (HCPCS) and associated CMS publications and services
- International Classification of Diseases (ICD)
- American Hospital Association's (AHA) Coding Clinic Guidelines
- Uniform Billing Editor
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services
- Food and Drug Administration (FDA) guidance
- Medical and surgical specialty societies and associations
- Industry-standard utilization management criteria and/or care guidelines
- Humana medical and pharmacy coverage policies
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published, peer-reviewed literature

Changes to any one of the sources may lead Humana Healthy Horizons to modify current or adopt new claims processing procedures.

These claims processing procedures may result in an adjustment or denial of reimbursement, a request for the submission of relevant medical records, prior to or after payment, or the recoupment or refund request of a previous reimbursement. You can access additional information at Humana.com.

An adjustment in reimbursement as a result of claims processing procedures is not an indication that the service provided is a non-covered service. Providers can submit a dispute request of any adjustment produced by these claims processing procedures by submitting a timely request to Humana. For additional information, see the Provider Disputes section of this manual.

Humana Healthy Horizons provides notification of upcoming code editing changes. We publish new code editing rules and our rationales for these changes on the first Friday of each month at Humana.com/Edits.

Prepayment Reviews for Fraud, Waste or Abuse Purposes

Humana Healthy Horizons will initiate prepayment review of claims within five business days of receipt of SCDHHS, Division of Program Integrity notification. A prepayment review is then conducted in a manner consistent with the request of the SCDHHS, Division of Program Integrity's notification. This prepayment review is conducted until Humana Healthy Horizons has been notified by SCDHHS, Division of Program Integrity to cease the prepayment review. Humana Healthy Horizons in South Carolina will also, at its discretion, place providers suspected of fraud, waste and abuse (FWA) on prepay review or otherwise take preventative actions as necessary to prevent further loss of funds. Prepayment reviews are conducted in accordance with state and federal laws.

Suspension of Provider Payments

A network provider's claim payments are subject to suspension when the SCDHHS Division of Program Integrity has determined that there is a credible allegation of fraud in accordance with 42 C.F.R. 455.23.

Coordination of Benefits (COB)

Humana Healthy Horizons 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.

While we try to maintain accurate information at all times, we rely on numerous sources for updated information periodically, and some updates may not always reflect on our provider portal.

Please ask Humana Healthy Horizons members for all healthcare insurance information at the time of service.

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

1. Member number
2. Case number
3. Medicaid number/MMIS number
4. Member name and date of birth

You can check COB information for members active with Humana Healthy Horizons within the last 12 months.

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

COB overpayment

When a provider receives a payment from another carrier after receiving payment from Humana Healthy Horizons for the same items or services, Humana Healthy Horizons considers this an overpayment. Humana Healthy Horizons provides at least 30 business days written notice to the

provider before an adjustment for overpayment is made. If a dispute is not received from the provider, adjustments to the overpayment are made on a subsequent reimbursement. Providers also can issue refund checks to Humana Healthy Horizons 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.

Member Billing

State requirements and federal regulations prohibit providers from billing Humana Healthy Horizons members for medically necessary covered services except under very limited circumstances. 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 stipulated in the Social Security Act.

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

Please remember that government regulations stipulate providers must hold members harmless in the event that Humana Healthy Horizons does not pay for a covered service performed by the provider. Members cannot be billed for services that are administratively denied. The only exception is if a Humana Healthy Horizons 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 his or her financial responsibility. The form or type of agreement must specifically state the services or procedures that are not covered by Medicaid.

Providers should call Provider Services at **866-432-0001** for guidance before billing members for services.

Missed Appointments

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

Member Termination Claim Processing

From Humana Healthy Horizons to another plan

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

- Humana Healthy Horizons 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. This process is completed within five business days.
- Humana Healthy Horizons sends out a notice to each affected provider that recoupment of payment will occur for the claim(s) identified in the recoupment letter. The provider is given at least 30 business days to respond to the notice.
- Once the minimum 30 business 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 adjusts the payment(s) for the affected claims listed in the notice letter. This takes place within 10 business days.
- After the recoupment receives a processed date stamp, a voided encounter for the affected claims is submitted to SCDHHS within 10 business days, assuming the original submitted encounter was previously accepted. Please note that if the original encounter was denied or rejected by SCDHHS, a void does not need to occur.

From another plan to Humana Healthy Horizons

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

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 180 days from the date of the accepted voided encounter to submit the claim to Humana Healthy Horizons to avoid timely filing denials.

Prior authorizations

It is important to request prior authorization as soon as the need for a service is identified.

Member eligibility is verified when a prior authorization is given for a service rendered during the same month as

the request. If the service is rendered during a subsequent month, prior authorization is given only if the treating provider is able to verify member eligibility on the date of service.

Humana Healthy Horizons is not able to pay claims for services provided to ineligible members.

All services that require prior authorization from Humana Healthy Horizons should be authorized before the service is delivered. Humana Healthy Horizons is not able to pay claims for services for which prior authorization was required but not obtained by the provider. Humana Healthy Horizons will notify you of prior-authorization determinations via fax. It is important to provide the correct contact information (phone and fax) on request.

Standard prior authorizations

For standard prior-authorization decisions, Humana Healthy Horizons provides notice to the provider and member as expeditiously as the member's health condition requires, but no later than 14 calendar days following receipt of the request.

Expedited prior authorizations

For cases in which a provider indicates, or Humana Healthy Horizons determines, that following the standard time frame could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function, Humana Healthy Horizons renders an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than 72 hours after receipt of the request. Please specify and provide supporting documentation if you believe the request should be considered expedited.

Authorization extensions

Both timeframes for standard and expedited reviews can be extended if, the member, the member's authorized representative, or the provider requests an extension, or if Humana Healthy Horizons justifies a need for additional information and the extension is in the member's best interest. Standard authorizations can be extended an additional 14 calendar days and expedited reviews can be extended up to 14 calendar days.

Medicaid services requiring prior authorization

Some services require prior authorization. Common codes requiring prior authorization are unlisted procedure codes. Unlisted procedure codes are services performed by a physician that are not specifically defined in the CPT book. These codes require the following:

- Prior authorization
- Report with a description of the nature, extent, and need for the procedure
- A comparative CPT code should be included in the report to determine reimbursement
- Manufacturer's invoice (if the code is for a drug or equipment)

To find out which additional services require prior authorization you can call Provider Services at **866-432-0001** or you can access the prior authorization list (PAL) at Humana.com/PAL.

Requesting prior authorization

This section describes how to request prior authorization for medical, radiology and behavioral health services. For pharmacy prior authorization information, refer to the Pharmacy section of this manual.

Humana Healthy Horizons accepts the following South Carolina Healthy Connections universal authorization forms:

- Universal 17-P/Makena Prior Authorization Form*
- Universal BabyNet Prior Authorization Form*
- Universal Newborn Prior Authorization Form*
- Universal Synagis Prior Authorization Form*

*These forms can be found on the South Carolina Healthy Connections Medicaid site in the Managed Care section under Reference tools: msp.scdhhs.gov/managedcare/site-page/reference-tools.

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

- Visit Availity Essentials at Availity.com
- Access various prior authorization forms online at South Carolina Medicaid Provider Prior Authorization - Humana
- Email completed forms to CorporateMedicaidCIT@humana.com
- Fax completed prior authorization forms to **833-441-0950**
- Call **866-432-0001** and follow the menu prompts for authorization requests, depending on your need

When requesting authorization, the following information will be requested. Please ensure this information is present within your request:

- Member/patient name and Humana ID number
- Provider name, NPI and TIN for ordering/servicing providers and facilities
- Anticipated date of service
- Diagnosis code and narrative

- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider, if applicable
- Clinical information to support the medical necessity of the service

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

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

Retrospective review

Prior authorization is required to ensure that services provided to our members are medically necessary and appropriately provided. Humana Healthy Horizons conducts retrospective reviews to determine whether authorization is granted for services rendered before a prior authorization for the services was requested. If you fail to obtain prior authorization before services are rendered, you have 180 days from the date of service, 180 days from the inpatient discharge date, or receipt of the primary insurance carrier's explanation of payment (EOP) to request a retrospective review of medical necessity. Requests for retrospective review that exceed these time frames are denied and ineligible for appeal.

A request for retrospective review can be made by calling **866-432-0001** and following the appropriate menu prompts. You may also fax the request to **833-441-0950**. Clinical information supporting the service must accompany the request

Continuity of Care

Members with continuity of care needs

If, at the time of enrollment, a new member is actively receiving medically necessary covered services from the previous MCO, Humana Healthy Horizons will provide continuation/coordination of such services for up to 90 calendar days or until the member may be reasonably transferred without disruption. Humana Healthy Horizons may require prior authorization for continuation of the services beyond 90 calendar days; however, under these circumstances, authorization is not denied solely on the basis that the provider is a non-contracted provider.

Pregnant women

When a pregnant new member is receiving covered, medically necessary services from the previous MCO in addition to, or other than, prenatal services, Humana Healthy Horizons will temporarily cover the costs of continuation of such medically necessary services. After 90 days, Humana Healthy Horizons may require prior authorization for continuation of services, but authorization is not denied at that point solely because of a provider's contract status. Humana Healthy Horizons may continue services uninterrupted for up to 90 calendar days or until the member may be reasonably transferred without disruption.

During the first and second trimester, Humana Healthy Horizons will cover the costs of continued medically necessary prenatal care services without any form of prior authorization and regardless of the provider's contract status until Humana Healthy Horizons can safely transfer the member to a network provider without impeding service delivery.

During the third trimester, Humana Healthy Horizons covers the costs of continued access to the prenatal care provider (whether contract or non- contract provider) for 60 calendar days post-partum, provided the member remains covered through Humana Healthy Horizons, or referral to a safety net provider if the member's eligibility terminates before the end of the post-partum period.

If you have additional questions regarding Humana's continuity of care process and authorizations for new members, please call **866-432-0001**.

Care Management and Care Coordination

Humana 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. Humana offers chronic condition management programs for behavioral health and substance use, as well as care management programs based on 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 including food pantry access and utility assistance.

Providers may contact Humana Healthy Horizons to refer members needing care management assistance by calling **866-432-0001** or via email at
Medical: SCMCDCareManagement@humana.com

Behavioral Health:
SCMCDCareManagement_BH@humana.com

HumanaBeginnings:
SCMCDHumanaBeginnings@humana.com

Humana adheres to a no-wrong door approach to care management referrals. Humana assists with provider referrals, appointment scheduling and coordination of an integrated approach to the member's health and well-being by coordinating care between behavioral health providers, primary care providers and specialists. 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.

The care management programs discussed in this section to follow are:

- Care management 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

Care management activities may integrate community health worker, peer or specialist support. Care 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.

Care management for low-risk members

Low-risk members typically require support with care coordination and in addressing social determinants of health (SDOH). These members have, at a minimum, quarterly telephonic outreach plan of care updates. Prevention and wellness messaging and condition-specific materials are also provided.

Care management for moderate-risk members

These members typically demonstrate rising risk and need focused attention to support their clinical care needs and to address SDOH. Focus is on interventions targeted at the member's specific problems and aims to improve overall health and prevent further illness/disease progression or increase in risk. These members have, at a minimum, monthly telephonic outreach and plan of care updates.

Intensive care management (ICM) for high-risk members

Members in ICM are those at high risk and require the intensive, highly 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.

Complex care management for members with complex needs

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, weekly contacts.

Chronic condition management program

The chronic condition management program provided by Humana is designed to:

- Improve member understanding and assist self-management of his/her disease with education and support while following a provider's plan of care
- Help members maintain optimal disease management and mitigate potential comorbidities by using interventions to influence behavioral changes
- Increase member compliance and disease-specific knowledge with plan of care via mailed materials, recommended websites and newsletters
- Ensure timely medical/psychological visits and appropriate utilization of access to care including home healthcare services
- Find and obtain community-based resources that meet the member's medical, psychological and social needs
- Develop routine reporting and feedback loops via phone, email or secure fax progress notes that may include communications with patients, physicians, health plan and ancillary providers
- Provide proactive health promotion education to increase awareness of the health risks associated with certain personal behaviors and lifestyles
- Evaluate clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall population health of chronic condition management program members

Chronic condition management includes assessment, monitoring, education, evaluation, instruction, intervention, and documentation of goals and outcomes of members with chronic conditions.

HumanaBeginnings® prenatal program

Humana's HumanaBeginnings® program provides perinatal and neonatal care management utilizing a staff of specialized nurses. Nurses are available to help manage high-risk pregnancies and premature births by working in conjunction with providers and members. The expertise offered by the staff includes a focus on patient education and support and involves direct telephone contact with

members and providers. We encourage our prenatal care providers to notify care management support services at **866-432-0001** when a member with a high-risk pregnancy is identified.

Care management participation and referrals

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

Member plans of care and health risk assessments are viewable on Humana's provider portal, Availity Essentials at Availity.com and are available on request by contacting our care management team at **866-432-0001**.

We offer individualized member education and support for many conditions and needs, including assistance with housing and accessing community support.

If you have a Humana Healthy Horizons in South Carolina covered patient with chronic conditions you believe would benefit from this program, you may have your patient reach us directly, or submit a referral on their behalf by calling Member/Provider Services at **866-432-0001** or you may email us:
Medical case management:
SCMCDCareManagement@humana.com

Behavioral health case management:
scmcdcaremanagement_bh@humana.com

HumanaBeginnings:
SCMCDHumanaBeginnings@humana.com

We encourage you to refer members who might need individual attention to help them manage special healthcare challenges.

Provider Disputes

A provider dispute may be filed online via Availity Essentials or via telephone, electronic mail, surface mail or in person.

On receipt of a dispute, the assigned Provider Dispute Resolution team investigates each dispute applying all 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 resolves the issue within the time period identified in the table below, titled "Dispute Q&A."

Providers can submit disputes for:

- Claims
- Non-claims topics including policies, procedures, rates, contract disputes, administrative functions, etc.

Disputes can be filed for:

- One member/claim
- One member and multiple claims
- Consolidated list of multiple members and claims when the claims involve the same or similar issues

Disputes can be submitted using the following steps:

- Online, via Availity Essentials:
  - Sign in at Availity.com; use the Claim Status tool to locate the claim and click the "Dispute Claim" button. Then go to the request in the Appeals worklist (located under Claims & Payments) to supply needed information and documentation and submit the request to Humana.
  - Status and high-level Humana determination for disputes submitted online can be viewed in the Appeals worklist.
  - For training opportunities, visit Humana.com/ProviderWebinars.
- Verbally, via telephone, by calling 866-432-0001. Hours of operation are 8 a.m. to 6 p.m., Eastern time, Monday-Friday.
- Via email, SCMCDProviderdispute@humana.com
- In writing, via surface mail:
  Humana Healthy Horizons in South Carolina
  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 Healthy Horizons in South Carolina office

The information that should be documented or submitted should include:

- Person calling, submitting or speaking with name, 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

Claims Dispute FAQ Topic	Response
How can disputes be submitted?	• Online via Availity Essentials: - Sign in at Availity.com; use the Claim Status tool to locate the claim and click the "Dispute Claim" button. Then go to the request in the Appeals worklist (located under Claims & Payments) to supply needed information and documentation and submit the request to Humana. - Status and high-level Humana determination for disputes submitted online can be viewed in the Appeals worklist. - For training opportunities, visit Humana.com/ProviderWebinars. • Verbally, via telephone by calling **866-432-0001**. Hours of operation are 8 a.m. to 6 p.m., Eastern time, Monday through Friday. • Via email, SCMCDProviderdispute@humana.com • In writing, via surface mail: Humana Healthy Horizons in South Carolina 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 Healthy Horizons in South Carolina office
What is the time frame for a provider to submit a claims dispute?	Within calendar 30 days of the date of the final determination of the primary payer
What communication and resolution time frame can be expected?	For digital, written and verbal complaints: • A resolution letter within 30 calendar days of receipt. • A status letter may be sent on the 30th day requesting a 15-day extension if more time is needed to resolve issue. Not to exceed 45 calendar days from date of receipt.
What if there are additional questions or concerns?	• Please contact us at **866-432-0001**. If you use a TTY, please call 711. • Our customer care representatives are available Monday through Friday from 8 a.m. to 6 p.m., Eastern time.

Member Grievances and Appeals

This section outlines the member's appeal rights and grievance process. For provider disputes regarding an issue you are having or with payment issues, please consult the Provider Disputes section of this manual.

Member grievance process

A grievance is any expression of dissatisfaction about any matter other than an adverse benefit determination. For more detail regarding the process, please consult the next section regarding the appeal process.

A grievance may include, but is not limited to, the quality of care or services provided, and aspects of interpersonal relationships including unprofessional conduct of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance also may include the member's right to dispute an extension of the time we take to make an appeal or grievance resolution.

A member, or the member's representative acting on their behalf, may file a grievance at any time after the date of the dissatisfaction. A provider may submit a grievance on behalf of the member only as the member's representative and with the member's written consent. If you would like to submit a grievance on behalf of your patient, please complete and send in the Appointment of Representative Form located at docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=639132.

When we receive a grievance, we will send a written acknowledgement of receipt within five business days.

We mail a written resolution letter to the member within 90 calendar days from the date we receive the grievance.

To submit a grievance orally, the member or their representative may call Member Services at 866-432-0001. Alternatively, a grievance may be submitted in writing at the following address:
Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax: 800-949-2961

Member appeal process

An appeal is a request for a review of an adverse benefit determination issued by Humana Healthy Horizons. The member, their authorized representative or the member's provider with the member's written consent, may file an appeal orally or in writing. The requestor may file an appeal orally via Member Services or in writing within 60 calendar days from the date on the notice of adverse benefit determination letter.

If the member wishes to have a representative, including their provider, represent them in an appeal, then he or she must complete an Appointment of Representative (AOR) form. The member and the representative must sign and date the AOR form that is located at docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=639132.

Providers can request reconsideration regarding post-service payment issues; see Provider Disputes section for more details.

It is important for us to receive all supporting documentation (such as medical records, supporting statements from a provider, etc.) in support of the appeal submission prior to the end of the appeal resolution time frame. For a standard appeal, we must receive this information within 30 calendar days of our receipt of your appeal. For an expedited appeal as outlined in the next section, we must receive all supporting information within 72 hours from when the appeal was received, whether verbally or in writing.

We do not take or threaten to take any punitive action against a provider acting on behalf of or in support of a member in requesting an appeal or an expedited appeal.

We ensure that decision makers for both grievances and appeals were not involved in any previous decision nor a subordinate of any individual involved in a previous decision. For appeals regarding a denial based on lack of medical necessity, a grievance due to a denial for an expedited resolution of an appeal, or any grievance or appeal involving clinical issues, the reviewers will be appropriate healthcare professionals with clinical expertise in treating the member's condition.

We provide our members reasonable assistance in completing forms and other steps to submit an appeal, including interpreter services and toll-free telephone numbers with TTY capability. Please refer to Interpreter Services for further information.

We acknowledge receipt of an appeal within five business days from the date we receive the request. For standard pre-service and post-service appeals, we make a decision and mail the notice communicating the decision within 30 calendar days of our receipt of the appeal.

If the member requests it, or if we need additional information to make a decision, and receiving that information is in the member's best interest, we may extend the standard appeal time frame by up to 14 calendar days. If we extend the time frame, we will notify the member orally and in writing. If the member disagrees with the extension of the resolution time frame, the member may file a grievance.

If we fail to meet the notice and timing requirements in this section, the member is deemed to have exhausted the internal appeals process and may initiate a State Fair Hearing.

Appeals may be submitted as follows:

- Online: Providers appealing a claim on behalf of a member may also do so online via Availity Essentials. To begin, use the Claim Status tool to locate the claim and click the "Dispute Claim" button. Then go to the request in the Appeals worklist (located under Claims & Payments) to supply needed information and documentation and submit the request to Humana. Status and high-level Humana determination for appeals submitted online can be viewed in the Appeals worklist. For training opportunities, visit humana.com/provider/medical-resources/self-service-portal/web-based-training
- Phone: To submit an appeal orally, you may call Member Services at **866-432-0001**.
- Mail or fax:
  Grievance and Appeals Department
  P.O. Box 14546
  Lexington, KY 40512-4546
  Fax: 800-949-2961

Member expedited appeals process

If following the standard 30 calendar-day time frame could seriously jeopardize the member's life or ability to attain, maintain or regain maximum function, you may request an expedited appeal. An expedited appeal request may be

filed by the member, their authorized representative or by the member's provider. An appeal where the requested services already have been rendered would never constitute an expedited appeal.

Anyone other than the member must obtain the member's written consent to file an expedited appeal on his or her behalf.

You may submit the request orally via Member Services or in writing within 60 calendar days from the date on the notice of adverse benefit determination letter at the above-mentioned address or fax number.

For expedited appeal requests, we make a determination as quickly as the member's health condition requires and send notification within 72 hours from the date and time we receive the expedited appeal request.

We also make reasonable efforts to provide oral notice of the appeal determination.

If the expedited appeal request does not meet expedited review criteria, we transfer the appeal to the standard appeal resolution time frame. We make reasonable efforts to provide oral notice of the expedited time frame denial and send a letter within two calendar days explaining the decision to deny the expedited resolution of the appeal request. If the member disagrees with the denial of the expedited time frame request, the member may file a grievance.

If the member requests it, or if we need additional information to make a decision, and receiving that information is in the member's best interest, we may extend the expedited appeal time frame by up to 14 calendar days. If we extend the time frame, we notify the member orally and in writing. If the member disagrees with the extension of the expedited resolution time frame, the member may file a grievance.

If we fail to meet to the notice and timing requirements in this section, the member is deemed to have exhausted the internal appeals process and may initiate a State Fair Hearing.

Right to examine appeal case file:

The member or someone they choose to act for them may:

- Review all the information used to make the decision
- Provide more information throughout the appeal review process
- Examine the case file before and during the appeals process
- This includes medical, clinical records, other documents and records, and any new or additional evidence considered, relied upon, or generated in connection with the appeal
- This information is provided, on request, free of charge and sufficiently in advance of the resolution timeframe.

Member state fair hearing process

When the member has exhausted the internal appeals process, and is dissatisfied with the internal appeal decision, the member may initiate a state fair hearing with SCDHHS within 120 calendar days from the date of receipt of the notice of appeal resolution. The member also may request a state fair hearing if we fail to adhere to the notice and timing requirements of the applicable appeal resolution time frame.

The member may appoint a representative in the state fair hearing process, however, the representative must obtain written consent from the member.

The state's standard time frame for reaching a decision is within 90 calendar days from the date the member or his or her representative filed the appeal, not including any days to file the request for fair hearing.

The member also may request an expedited hearing. SCDHHS grants or denies these requests as quickly as possible on receipt. If the state grants an expedited hearing, a decision is made within three business days. If request to expedite the hearing is denied, the hearing follows the standard 90-day timeframe.

Continuation of benefits while appeal and state fair hearing is pending

While the state fair hearing or appeal are pending, we continue paying for the member's benefits if all of the following conditions are met:

- The member, provider, or appointed representative files an appeal within 10 calendar days of the date the notice of adverse benefit determination was mailed, or the intended effective date of the adverse decision, whichever is later.
- The appeal involves the termination, suspension, or reduction of previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The original period covered by the original authorization has not yet expired; and
- The member requests the benefits to continue (providers are unable to request the member's benefits continue).

If the member requests a continuation or reinstatement of the member's benefits while the appeal or state fair hearing is pending, we continue benefits until one of the following occurs:

- The member withdraws the appeal or state fair hearing
- 10 calendar days have passed after the date on the adverse appeal resolution notice, unless within the 10-

day time frame, the member has requested a state fair hearing with continuation of benefits until a decision is reached.
- A state fair hearing officer issues a decision adverse to the member.

If the state fair hearing is decided in the member's favor, Humana approves the services within 72 hours from the date we receive notice of the favorable decision.

If the resolution of the appeal or state fair hearing is adverse to the member and the action is upheld, we may recover the cost of services furnished to the member while the appeal or hearing was pending, to the extent that services were furnished as described in the requirements in this section and in accordance with 42 CFR 431.230(b).

Provider Rights and Responsibilities

Provider rights

When you contract with SCDHHS or subcontract with Humana to furnish services to Humana Healthy Horizons in South Carolina members you are assured of the following rights:

1. When acting within the lawful scope of practice, providers are not prohibited from advising or advocating on behalf of a Humana Healthy Horizons 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's policies and procedures covering the authorization of services.
4. To be notified of any decision by Humana 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 South Carolina members, the denial of coverage of, or payment for, medical assistance.
6. To be free from discrimination from Humana's provider selection policies and procedures for serving high-risk populations or specializing in conditions that require costly treatment.
7. To be free from discrimination for the participation, reimbursement, or indemnification of any provider who acts within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

Provider responsibilities

To comply with the requirements of accrediting and regulatory agencies, Humana Healthy Horizons 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 provider agreement. You must:

- Have a professional degree and a current, unrestricted license to practice medicine in the state in which provider's services are regularly performed.
- Be enrolled as a Qualified Medicaid Provider with SCDHHS and have a unique South Carolina Medicaid provider number and NPI. Humana, on request, assists SCDHHS to periodically revalidate South Carolina Medicaid provider status and Humana may deny claim reimbursement for covered services if it determines that you do not have a South Carolina Medicaid provider number at the time it adjudicates a claim.
- Agree to comply with Humana'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.
- Be credentialed by Humana and meet all credentialing and re-credentialing criteria as required by Humana and SCDHHS.
- Be subject to civil monetary penalties if you employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries (See Section 1128A(a) (6) of the Social Security Act and 42 CFR § 1003.102).
- Provide documentation on your 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 you make member rounds and have no record of reduced, denied or limited hospital privileges or if so, provide an explanation that is acceptable to Humana.
- Assume responsibility for member's receiving post stabilization care at a hospital to which you have privileges until either the member is transferred, agreement is reached between the treating provider and Humana concerning the member's care or discharged.
- Inform Humana in writing within 24 hours of any revocation or suspension of your Bureau of Narcotics and Dangerous Drugs number and/or of suspension, limitation or revocation of your license, reduction and/or denial of hospital privileges, certification, CLIA certificate or other legal credential authorizing you to practice in any state in which you are licensed.
- **Inform Humana immediately** of changes in licensure status, TIN, NPI, telephone numbers, addresses, status at participating hospitals, your 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 your participation status with Humana Healthy Horizons.
- 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.
- Not discriminate in any manner between Humana Healthy Horizons members and non- Humana Healthy Horizons members.
- Inform members regarding follow-up care or provide training in self-care.
- Assure the availability of physician services to members 24 hours a day, seven days a week.
- Arrange for on-call and after-hours coverage by a participating and credentialed Humana Healthy Horizons provider.
- Ensure that health records or other appropriate documentation for each member substantiate the need for services, must include all findings and information supporting medical necessity and justification for services, and must detail all treatment provided.
- Refer Humana Healthy Horizons in South Carolina members with problems outside your normal scope of practice for consultation and/or care to appropriate specialists contracted with Humana Healthy Horizons on a timely basis, 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 member, other than for copayments, deductibles, coinsurance, other fees that are the member's responsibility under the terms of their benefit plan.
- Provide services in a culturally competent manner, (e.g., 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 are made available by the U.S. Department of Health and Human Services, Office of Minority Health (e.g., minorityhealth.hhs.gov and thinkculturalhealth.hhs.gov/).
- Provide access to healthcare benefits for all members in a manner consistent with recognized standards of healthcare 42 C.F.R. 422.504(a)(3)(iii)/ and SCDHHS requirements and covered in this manual.
- Provide or arrange for continued treatment to all members including, but not limited to, medication therapy, upon 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 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.
- The subcontractor shall safeguard information about Medicaid managed care members according to applicable state and federal laws and regulations including but not limited to 42 CFR 431, Subpart F, and Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164.

- Provide an electronic automated means, at request of Humana and at no cost, for Humana Healthy Horizons and all its affiliated vendors acting on behalf of Humana Healthy Horizons, 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 providers on request and at no charge to Humana, the member or the requesting party, unless otherwise agreed.
- Provide copies of, access to and the opportunity for Humana or its designee to examine office books, records and operations of any related organization or entity involving transactions related to health services provided to members. A related organization or entity is defined as having:
  - Influence, ownership, or control and:
  - Either a financial relationship or a relationship for rendering services to the primary care office.
  - The purpose of this access is to help guarantee compliance with all financial, operational, quality assurance: peer review obligations, as well as all other provider obligations stated in the agreement or in this manual. Failure by any person or entity involved, including the provider, to comply with any requests for access within 10 business days of receipt of notification are considered a breach of contract. For records related to Humana Healthy Horizons members, this access right is for the time stipulated in the agreement or the time period since the last audit, whichever is greater.
- Assume full responsibility to the extent of the lawand to the extent applicable to the physician, when supervising/ sponsoring, whether through a protocol, collaborative, or some other type of agreement, physician assistants (PAs) advanced practice registered nurses (APRNs), nurse practitioners (NPs) and all other healthcare professionals required to be supervised or sponsored, whether through a protocol, collaborative, or some other type of agreement under applicable federal and state law so as to treat members.
- Use physician extenders to provide direct care to members that is within the scope of practice that complies with South Carolina rules and regulations and Humana guidelines.
- Schedule with a physician rather than a physician extender if the member communicates physician preference.
- 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.
- 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.
- Perform services under the agreement shall be consistent and in compliance with Humana's contractual obligations under its South Carolina Medicaid contract(s). You agree to cooperate with and assist Humana in its efforts to comply with its South Carolina Medicaid contract(s) and/or rules and regulations and to assist Humana in complying with corrective action plans necessary for Humana to comply with such rules and regulations.
- Submit complete member referral information when applicable and in a timely manner to Humana via electronic means or telephone.
- Notify Humana Healthy Horizons of scheduled surgeries/ procedures requiring inpatient hospitalization.
- Notify Humana Healthy Horizons of any material change in provider's performance of delegated functions, if applicable.
- Notify Humana of your termination 90 days prior to the effective date of termination.
- Cooperate with an independent review organization's activities pertaining to the provision of services for Medicaid members. Respond expeditiously to Humana's requests for medical records or any other documents to comply with regulatory requirements and to provide any additional information about a case in which a member has filed a grievance or appeal.
- Abide by the rules and regulations and all other lawful standards and policies of the Humana plan(s) with which the provider is contracted, including Humana Healthy Horizons in South Carolina.
- Have an effective compliance program in place.
- Review and adhere to Humana's Ethics Every Day for Contracted Healthcare Providers and Third Parties.
- 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.

- Understand that this manual also applies to any downstream agreement(s) with physicians or other providers who provide services to Humana Healthy Horizons members, and you/your organization agree to provide a copy of said agreement(s) to Humana on request (financial information is not requested). The subcontract or delegation includes all stated requirements of the contract with us, including, but not limited to information submission, if applicable, for management covered services.

The provider agrees to:

- Abide by all state and federal laws regarding confidentiality, privacy and disclosure of medical records or other health and enrollment information.
- Submit a claim on behalf of the member in accordance with timely filing laws, rules, regulations and policies.
- Pay court costs and/or legal fees incurred by Humana or the member to enforce the terms of this provision.
- Understand and agree that provider performance data can be used by Humana.

The following is a high-level overview of your compliance and ethics expectations:

- Have an effective compliance program in place
- Review and adhere to the requirements outlined within these separate Humana documents:
- Ethics Every Day for Contracted Healthcare Providers and Third Parties
- Compliance Policy for Contracted Healthcare Providers and Third Parties
- Doing the 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
- Please visit Humana.com/providercompliance to access these documents and other annual compliance training and attestation requirements.
- Act according to professional ethics and business standards
- Conduct exclusion screenings prior to hire/contract and monthly thereafter of those slated to support Humana, 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 exclusion lists
- 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 Humana identifies 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

Primary care providers (PCPs) responsibilities

The PCP serves as the member's initial and most important point of interaction with our provider network. A PCP is an individual physician, nurse practitioner or physician assistant who accepts primary responsibility for the management of a member's healthcare. 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 members choose or are assigned to a PCP on enrollment with Humana. We will only assign members to a nurse practitioner or physician assistant when members notify us of the selection. This means that PCPs help coordinate healthcare for the member and provide additional health options to the member for self-care or care from community partners. PCPs also are required to know how to screen and refer members for behavioral health conditions.

Members select a PCP from our Humana Healthy Horizons 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 are:

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

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

- Availability of a personal healthcare practitioner to assist with coordinating a member's overall care, as appropriate for the member
- Continuity of the member's total healthcare
- Early detection and preventive healthcare services
- Elimination of inappropriate and duplicate services
- Services that are appropriate and do not duplicate other previously delivered services

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

- Treating Humana Healthy Horizons members with the same dignity and respect afforded to all patients – including high standards of care and the same hours of operation.
- 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 subspecialists and subspecialty 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 the care of individual patients.
- Providing the coordination necessary for referring patients to specialists and for second opinions.
- Report instances of tuberculosis and other communicable diseases to South Carolina Department of Health and Environmental Control for clinical management, treatment and direct observed therapy.
- 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.
- Development of plans of care to address risks and medical needs and other responsibilities as defined in this section.
- Ensuring that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in 45 C.F.R. Parts 160 and 164 and all state statutes. 45 C.F.R. Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information.
- Providing after-hours availability to patients who need medical advice. At a minimum, the PCP office must have a return-call system staffed and monitored to ensure that the member is connected to a designated medical practitioner within 30 minutes of the call.
- Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an in-network hospital.
- Working with Humana case managers to develop plans of care for members receiving care management services.
- Participating in the Humana's care management team, as applicable and medically necessary.
- Conducting screens for common behavioral issues, including, but not limited to, depression, anxiety, trauma/adverse childhood experiences (ACEs), and 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.
- Maintaining continuity of the member's healthcare.
- Identifying the member's health needs and taking appropriate action.
- Providing phone coverage for handling patient calls 24 hours a day, seven days a week.
- Making referrals for specialty care and other medically necessary services, both in- and out-of-network, if such services are not available within the Humana Healthy Horizons network.
- Following all referral and prior-authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of Humana Healthy Horizons and SCDHHS as outlined in this manual.
- Discussing advance medical directives with all members as appropriate.
- Providing 30 days of emergency coverage to a Humana Healthy Horizons covered member dismissed from the practice.
- Maintaining clinical records, including information about pharmaceuticals, referrals, in-patient history and documentation of all PCP and specialty care services, etc., in a complete and accurate medical record that meets or exceeds SCDHHS specifications.
- Obtaining patient records from facilities visited by Humana Healthy Horizons members for emergency or urgent care, if notified of the visit.
- Ensuring demographic and practice information is up to date for directory and member use.
- Referring members to behavioral healthcare providers and arranging appointments, when clinically appropriate.
- Assisting with coordination of the member's overall care, as appropriate for the member.

- Serving as the ongoing source of primary and preventive care, including Early and Periodic Screening, Diagnostic and Treatment (ESPDT) for persons younger than 21.
- Recommending referrals to specialists, as required.
- Participating in the development of care management and treatment plans and notifying Humana of members who may benefit from care management.
- Maintaining formalized relationships with other PCPs to refer their members for after-hours care, during certain days, for certain services or other reasons to extend their practices.

Advance directives

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

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

- All member records must 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 or not the member has executed an advance directive. (42 CFR 438.3(j)(3));
- Neither the managed care plan, nor any of its providers should, 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)).

PCP request for member transfer

PCPs may request a member's disenrollment from their practice and reassignment to a new PCP under the following circumstances:

- Incompatibility of the PCP/patient relationship
- Inability to meet the medical needs of the member

Humana Healthy Horizons' involuntary dismissal from a PCP's practice policy includes the following reasons:

1. Incompatibility of the PCP/patient relationship where the member does not respond to recommended patterns of treatment of behavior. Examples include:
   - Repeated failure to modify behavior as requested
   - Repeated noncompliance with medication schedules
   - Repeated violation of no-show office policies
   - The PCP must document at least three attempts in person, by mail and/or phone to communicate recommended patterns of treatment or behavior required to continue serving the member as their PCP.
2. Inability to meet the medical needs of the member.
   - This must be communicated to the member in person, via phone, or in writing at least once.

Once required communications and outreach attempts are made, the PCP office may initiate issuance of the involuntary dismissal notice. When the PCP office has a member in its care who meets one of the reasons previously outlined, and the required documentation is complete, the PCP can initiate dismissal procedures by:

- Notifying the member of dismissal by certified letter, which must include the following details:
  - The reason for the dismissal
  - The specific dates of the documented unsuccessful education/communication attempts and/or communication that the provider is unable to meet the member's needs
  - Notification that the member must contact Humana Healthy Horizons in South Carolina member services at **866-432-0001** to choose another PCP
- Emailing a copy of the letter to Humana Healthy Horizons to scmedicaid@humana.com.
  - The provider's notification to Humana Healthy Horizons in South Carolina must include the following:
    - Provider name
    - Provider tax identification number
    - Provider address and phone
    - Member name
    - Member ID number
    - Member address and phone
    - Member date of birth
    - Copy of the certified dismissal letter that was sent to the member

PCP quality recognition programs

Humana Healthy Horizons is committed to improving cost and care in the communities we serve. We developed value-based programs that allow PCPs to earn financial incentives based on quality and clinical outcomes. The programs are designed based on the provider's panel size and their engagement. The programs are reviewed and reimbursed annually. Annual payments are made in the following quarter to allow for reporting/data collection.

Access to care requirements

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 (FFS) members, if the provider serves only Medicaid managed

care members. Participating primary care providers 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). The member should have access to care for PCP services and referrals to specialists for medical and behavioral health services available on a timely basis, as follows:

Appointments for urgent medical or behavioral healthcare services shall be provided:

a) Within 48 hours of a request for primary care or behavioral healthcare.
b) Within 48 hours of referral or notification from primary care physician for specialty care.

Appointments for routine and wellness visits should be provided:

a) Within four to six weeks of member's request for primary care physician appointment.
b) Within four weeks of member's request for medical/ behavioral health specialty appointment and a maximum of 12 weeks for unique specialists.

Emergency services should be provided:

a) Immediately on presentation at a primary care physician service delivery site.
b) Immediately on receiving referral for emergent medical/behavioral health specialty visit.

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

- In-office waiting times for any scheduled medical service visit can not exceed 45 minutes.
- Walk-in members with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.
- Provider offices must offer hours of operation that are no less than the hours of operation offered to commercial patients or comparable to Medicaid FFS, if the provider serves only Medicaid managed care members.
- Provide female members with direct access to a women'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 the member's designated source of primary care if that source is not a women's health specialist.
- Provide for a second opinion from a qualified healthcare professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member.

Personally identifiable information and protected health information

In the day-to-day business of patient treatment, payment and healthcare operations, Humana Healthy Horizons 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 take measures to secure your patients' data.

You also are mandated by the 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.

Member consent to share health information

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

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

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

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

Education

Humana Healthy Horizons conducts an initial educational orientation (either online or in-person) for all newly contracted providers within 30 days of activation. Providers receive periodic and/or targeted education as needed. Benefit/direct service provider training sessions are held annually in at least four regional locations throughout the state.

Required training

We expect adherence to all training programs identified as compliance-based by the contract and Humana. This includes agreement and assurance that all affiliated participating providers, along with supporting you and your staff with member interaction* receive training on the identified compliance material.

*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 correspondence via mail, email or fax.

Annual compliance training must be completed on the following topics, as required by Section 6032 of the Federal Deficit Reduction Act of 2005, Humana's contract with the

South Carolina Department of Health and Human Services and/or our compliance program:

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

Note: An attestation at the organization level must be submitted annually to us to certify that your organization has a plan in place to comply with and conduct training on Medicaid required 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 members of Humana Healthy Horizons
- The presence of specific controls to prevent, detect and/or correct potential, suspected or identified noncompliance and/or fraud, waste or abuse

All new providers also will receive Humana Healthy Horizons in South Carolina's Medicaid provider orientation.

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

For additional provider training:
Visit Humana.com/HealthySC.

**Your organization is responsible for developing or adopting another organization's training on the separate topics of general compliance and combatting fraud, waste and abuse. While Humana does not require an organization-level attestation regarding training on these topics, we reserve the right to at any time request evidence that such training occurs and is sufficient.

Key contract provisions

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

These contract elements strengthen our relationship with you and enable us to meet or exceed our commitment to improve the healthcare and well-being of our members. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of our members.

Unless otherwise specified in a provider's contract, the following standard key contract terms apply. Participating providers are responsible for:

- Providing Humana with advance written notice of intent to terminate an agreement with us. Notice must be given at least 90 days prior to the date of the intended termination and submitted on your organization's letterhead.
- Sending the required 60-day notice if you plan to close your practice to new patients. If we are not notified within this time period, you are required to continue accepting Humana Healthy Horizons in South Carolina members for a 90-day period following notification.
- Providing 24-hour availability to your Humana Healthy Horizons covered members by telephone (for PCPs only). Whether through an answering machine or a taped message used after hours, members have the ability to contact their PCP or a back-up physician to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up physician and only recommends emergency room use for after hours.
- Submitting claims and corrected claims within one year from the date of service or discharge.
- Filing written disputes within 30 calendar days from the receipt of a Notice of an Adverse Action.
- Keeping all demographic and practice information up to date.

By agreement, Humana is responsible for:

- Paying 90% of all clean claims from providers, including Indian healthcare providers, within 30 calendar days of the date of receipt; and pay 99% of all clean claims from providers, including Indian healthcare providers, within 90 calendar days of the date of receipt.
- Providing you with a provider dispute process for timely resolution of requests to reverse a Humana determination regarding claim payment. Our provider dispute process is outlined in the Provider Disputes section of this manual.
- Offering a 24-hour nurse triage phone service for members to reach a medical professional at any time with questions or concerns.
- Coordinating benefits for members with primary insurance, up to our allowable rate for covered services. If the member's primary insurance pays a provider equal to or more than the Humana Healthy Horizons fee schedule for a covered service, Humana does not pay any additional amount. If the member's primary insurance pays less than the Humana Healthy Horizons fee schedule for a covered service, Humana reimburses the difference up to the Humana Healthy Horizons allowable rate.

These are just a few of the specific terms of our agreement. We expect participating providers to follow industry standard-practice procedures even though they may not be expressly stated in our provider agreement

Required provider identifiers

You must be eligible for participation in the Medicaid program. If currently suspended or involuntarily terminated from the South Carolina Medicaid program whether by contract or sanction, other than for purposes of inactivity, you are not considered an eligible Medicaid provider.

It is your responsibility to ensure you have a unique South Carolina Medicaid provider number in accordance with the guidelines of SCDHHS. You are also required to have a 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.

To comply with reporting requirements, Humana verifies current South Carolina Medicaid provider status using data provided by SCDHHS. Humana may deny reimbursement for covered services if it determines that you do not have a current South Carolina Medicaid provider number at the time it adjudicates the claim.

Contractual and demographic changes

As a contracted provider, notifying Humana Healthy Horizons in South Carolina 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 provider's TIN
- New providers added to group
- Providers leaving group
- Service address changes, e.g., new location, phone, fax
- Accessible to public transportation
- Standard hours of operation and after hours
- Billing address updates
- Credentialing updates
- Panel status
- Languages spoken in office

Notification of changes should be sent via email to:

- Medical providers at scproviderupdates@humana.com
- Behavioral health providers at scbhmedicaid@humana.com

You are strongly encouraged to provide your race and ethnicity for Humana to reference when a member calls requesting a practitioner with the same race, ethnicity, and language as themselves.

Americans with Disabilities Act (ADA)

All Humana-contracted healthcare providers must comply with the 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 develops individualized care plans that take into account members' special and unique needs. If you have members who require interpretive services your office may contact your provider relations representative with questions.

If you have members who need interpretation services, they can call the number on the back of their member ID cards or visit Humana's website at: Humana.com/accessibility-resources.

Cultural competency

Your office is 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.

Compliance with 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 also is required.

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

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

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

Humana Healthy Horizons 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 https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=3027154. To request a paper copy, please contact Humana Healthy Horizons in South Carolina Provider Service at **866-432-0001**.

Humana also offers training material on this topic at Humana.com/providercompliance.

Member Rights and Responsibilities

As a Humana Healthy Horizons provider, you are required to respect the rights of our members. Humana Healthy Horizons members are informed of their rights and responsibilities via their member handbook. The list of our member's rights and responsibilities is below.

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

- To accept or refuse medical, surgical, or behavioral health care. Any changes will be updated in the member handbook as soon as possible, but no later than 90 calendar days after the effective date of the change.
- To prepare advance medical directives. All changes are updated in the member handbook as soon as possible, but no later than 90 calendar days after the effective date of the change.
- To receive all services that the plan must provide and to get them in a timely manner.
- To get timely access to care without any communication or physical access barriers.
- To have reasonable opportunity to choose the provider that delivers care whenever possible and appropriate.

- To choose a PCP and change to another PCP in Humana Healthy Horizons' network. The member will receives written notification that confirms the PCP change.
- To change providers.
- Request a practitioner that has their same race, ethnicity and language if there is a practitioner available in the network.
- To be able to get a second opinion from a qualified provider in or out of our network. If a qualified provider is not available, we must set up a visit with a provider not in our network.
- To get timely access and referrals to medically indicated specialty care.
- To be protected from liability for payment.
- To receive information about their health. This information also may be given to someone the member has legally approved to have the information, or to someone the member said should be reached in an emergency, when it is not in the best interest of the member's health to receive the information directly.
- To ask questions and get complete information about their health and treatment options in a way that they can understand. This includes specialty care.
- To have a candid discussion of any appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
- To take an active part in decisions about their healthcare unless it is not in their best interest.
- To say yes or no to treatment or therapy. If they say no, the doctor or Humana Healthy Horizons must talk to them about what could happen. A note must be placed in the medical record.
- To be treated with respect, dignity, privacy, confidentiality, accessibility and nondiscrimination.
- To have access to appropriate services and not be discriminated against based on health status, religion, age, gender or other bias.
- To be sure that others cannot hear or see members when getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease or revenge, as specified in federal laws.
- Receive information in accordance with 42 CFR 438.10.
- Be furnished healthcare services in accordance with 42 CFR438.206 through 438.210.
- Any Indian enrolled with Humana Healthy Horizons eligible to receive services from a participating I/T/U provider or an I/T/U primary care provider shall be allowed to receive services from that provider if part of Humana Healthy Horizons' network. I/T/U stands for Indian Health Service, Tribally Operated Facility/ Program, and Urban Indian Clinic.
- To get help with their medical records in accordance with applicable federal and state laws
- To be sure that their medical records are kept private
- To ask for and receive a copy of their medical records, and to be able to ask that their health records be changed or corrected if needed. Records are retained for 5 years or longer as required by federal law.
- To say yes or no to having information given out unless Humana Healthy Horizons must provide it by law.
- To be able to get all written member information at no cost in:
  - The prevalent non-English languages of members in our service area
  - Other ways to help with the special needs of members who have trouble reading the information for any reason
- To get help, free of charge, from Humana and our providers if they do not speak English or need help to understand information.
- To get help with sign language if hearing impaired.
- To be told if a healthcare provider is a student and be able to refuse his or her care
- To be told if care is experimental and be able to refuse to be part of the care
- To know that Humana Healthy Horizons in South Carolina must follow all federal, state, and other laws about privacy that apply. This includes procedures for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth with parental notice or consent.
- To be able to go to a woman's health provider in our network for covered woman's health services.
- To file an appeal or grievance or request a state fair hearing.
- To get help with filing an appeal or a grievance. Members can ask for a state fair hearing from Humana Healthy Horizons and/or the SCDHHS. To make advance directives, such as a living will.
- To contact the Office of Civil Rights with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.

Office for Civil Rights
Sam Nunn
Atlanta Federal Center
62 Forsyth Street, S.W. Suite 16T70
Atlanta, GA 30303-8909
Phone: 800-368-1019
TDD: 800-537-7697
Humana.com
Fax: 202-619-3818

- To receive information about Humana Healthy Horizons, our services, our practitioners and providers, and member rights and responsibilities.
- To make recommendations to our member rights and responsibility policy.
- If Humana Healthy Horizons is unable to provide a necessary and covered service in our network, we will cover these services out of network. We will do this for as long as we cannot provide the service in network. When approved to go out of network, this is their right as a member. There is no cost.
- To be free to carry out their rights and know that Humana Healthy Horizons and/or our providers do not hold this against them.

Member responsibilities

- Work with their PCP to protect and improve their health.
- Find out how their health plan coverage works.
- Listen to their PCP's advice and ask questions when in doubt.
- Call or go back to their PCP if not getting better or ask to see another provider.
- Treat healthcare staff with the respect.
- Tell us if they have problems with any healthcare staff by calling Member Services at 866-432-0001 (TTY: 711).
- Keep their appointments and calling as soon as possible if they must cancel.
- Use the emergency department only for real emergencies.
- Call their PCP when medical care is needed, even if it is after-hours.

Members of Humana Healthy Horizons, must be sure to:

- Know their rights.
- Follow Humana Healthy Horizons in South Carolina and South Carolina Medicaid 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 possible about their health issues.
- Take part in reaching goals that are agreed upon with their healthcare provider.
- Let Humana know if they suspect healthcare fraud or abuse.
- Let Humana know if when unhappy with us or one of our providers.
- Use only approved providers.
- Report any suspected fraud, waste or abuse using the information provided in this manual.
- Keep scheduled doctor visits. Be on time. If necessary to cancel, call 24 hours in advance.
- Follow the advice and instructions agreed upon with their doctors and other healthcare providers.
- Always carry and show their member ID card when receiving services.
- Never let anyone else use their member ID card.
- Let us know of a name, address, or phone number change, or a change in the size of their family. Humana Healthy Horizons wants to make sure we are always able to connect with members about their care. Let us know about births and deaths in their family. We also encourage members to report changes to their local SCDHHS.
- Call their PCP after going to an urgent care center, a medical emergency, or getting medical care outside of Humana Healthy Horizons' service area.
- Let Humana Healthy Horizons and the SCDHHS know of any other health insurance coverage.
- Provide the information that Humana Healthy Horizons and their healthcare providers need in order to provide care.
- Report suspected fraud, waste, or abuse.
- Notify us immediately of any worker's compensation claim, a pending personal injury or medical malpractice law suit, or if they have been involved in an auto accident.

Humana Healthy Horizons in South Carolina advises members of any changes to our member rights and responsibilities on our website at Humana.com/HealthySouthCarolina.

Quality Improvement

Overview

Humana Healthy Horizons' Quality Improvement Program (QI Program) is a comprehensive quality improvement program that encompasses clinical care, preventive care, population health management, behavioral health 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. Chaired by the health plans's Chief Medical Officer, the Quality Assurance Committee (QAC) 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 goals of the QI Program are to:

- Develop clinical strategies and providing clinical programs that look at the whole person, while integrating behavioral and physical health care.
- Identify and resolve issues related to member access and availability to health care services.
- Identify and track adverse or critical incidents and review and analyze adverse or critical incidents to identify and address and/or eliminate potential and actual quality of care and/or health and safety issues.
- Provide a mechanism where members, practitioners, and providers can express concerns to Humana regarding care and service.
- Provide effective customer service for member and provider needs and requests.
- Provide a process for selecting and directing task forces, committees or other health plan activities to review areas of concern.
- Monitor coordination and integration of member care across provider sites.
- Monitor, evaluate and improve 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.
- Provide a comprehensive strategy for population health management that addresses member needs across the continuum of care.
- Provide mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.
- Provide mechanisms to detect both underutilization and overutilization.
- Provide mechanisms where members with complex needs and multiple chronic conditions can achieve optimal health outcomes.
- Guide members to achieve optimal health by providing tools that help them understand their healthcare options and take control of their health needs.
- Monitor and promote the safety of clinical care and service.
- Adopt reimbursement models that incentivize the delivery of high-quality care.
- Provide practitioners with comparative data regarding quality and pricing information to support achievement of population health management goals.
- Promote better communication between departments and improved service and satisfaction to members, practitioners, providers and associates.
- Promote 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' QI Program, which includes providing member records for assessing quality of care. In addition, HIPAA Privacy Rule of 45 CFR 164.506 and rules and regulations promulgated thereunder (45 CFR Parts 160, 162, and 164) permit 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 to use provider performance data.

Humana Healthy Horizons 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' quality improvement program and its progress toward goals, contact Provider Services at **866-432-0001**.

Member satisfaction

On an annual basis, Humana Healthy Horizons 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' 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 including professional medical associations, voluntary health organizations and National Institutes of Health (NIH) Centers and Institutes. They help providers make decisions regarding appropriate healthcare for specific clinical circumstances. Humana strongly encourages providers to use these guidelines and to consider these guidelines whenever there is opportunity to promote positive outcomes for patients. The provider remains responsible for ultimately determining the applicable treatment for each individual.

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

Providers also can receive preventive health and clinical practice guidelines through the care management department or their Provider Relations representative. Clinical practice 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 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 ending a HEDIS improvement opportunity.
- Standard supplemental data flows directly from one electronic database e.g. population health system, EMR, to another without manual interpretation. Therefore, standard supplemental data is exempt from audit consideration. Standard supplemental data can be accepted via HEDIS-specific custom reports extracted directly from the provider's EMR or population health tool and is submitted to Humana Healthy Horizons via either secure email or FTP transmission. Humana also accepts lab data files in the same way. Humana Healthy Horizons partners with various EMRs to provide member summaries and detail reports and to automatically retrieve scanned charts.

Health records

Providers must maintain a comprehensive health record that reflects all aspects of care for each member. Providers must maintain medical records in a secure, timely, legible, current, detailed, accurate and organized manner to permit effective and confidential patient care and quality review. Records should be safeguarded against loss, destruction or unauthorized use and must be accessible for review and audit. Such records must be readily available to the SCDHHS 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, sex, gender, marital status, race/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 (signed and dated as applicable), identify language spoken, and if applicable, need for communication assistance, and guardianship information, Medicaid identification number
- Services provided through the MCO, date of service, and data entry, service site and name of service provider.
- Provider identification by name
- Allergies or no known allergies must be documented, in a prominent location in the medical record; medication and other adverse reactions must be listed, if present
- Past medical history, including serious accidents, operations and illnesses, diagnosis, prescribed treatment and/or therapy, drugs administered/dispensed. The health record shall commence on the date of the first patient examination made through, or by Humana Healthy Horizons in South Carolina

*For pediatric patients (younger than 21 years of age), past medical history includes prenatal care and birth information, operations and childhood illnesses e.g., documentation of chickenpox

- Past surgical history
- Family and/or hereditary history
- Past medical records reviewed, filed and initialed
- 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, follow-up and outcome of referrals should be noted
- Documentation of immunizations: record of immunization status and a current record of immunizations should appear in the patient chart
- Preventative screenings are offered or referred, e.g.. EPSDT, breast cancer screening, cervical cancer screenings, eye exams
- Identification and history of smoking/vaping nicotine, alcohol use or substance use for all members 12 years of age and older
- Interval history including after hours/hospital follow-up. If member had these services: documentation of emergency department and/or after-hours encounters; hospital reports including admission and discharge summaries; follow-up visits and results/outcomes. Follow-up visits provided secondary to reports of emergency room care
- Advance medical directives (for members 18 and older): documentation of evidence that the member was asked if he or she has an Advance Directive (yes or no response should be documented); documentation of Advance Directive, if completed (if yes), evidence of discussion about Advance Directive (if no),
- All written denials of service and the reason for the denial
- 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.
- The record must be legible to someone other than 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 each individual clinical encounter:

- Date and location of service
- Purpose of visit, 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 findings:
  - Physical exam (complete): all body systems should be reviewed within one year of the first clinical encounter or all body systems must be reviewed upon first visit, including head, eyes, ears, nose and throat (HEENT), teeth, neck, heart, lungs, neurological and musculoskeletal
  - Vital signs: height, weight, body mass index (BMI) percentile, blood pressure and temperature must be documented
- Subjective findings:
  - History/description of symptoms/current problem list, containing relevant psychologica and social conditions affecting the patient's medical/behavioral health, including mental health status, patient's pain level
- 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 dose, amount, directions for use and refills
  - Therapies and other prescribed regimen
  - Health education provided
  - Follow-up plans including consultation, referrals and directions

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 (mental hospitals) or 42 C.F.R. 456.70 (hospitals).
- Initial and subsequent continued stay review dates (described under 42 C.F.R. 456.233 and 42 C.F.R. 465.234 [for mental hospitals] and 42 C.F.R. 456.128 and 42 C.F.R.456.133 (for hospitals)
- Reasons and plan for continued stay if applicable
- Other supporting material appropriate to include
- Reasons and plan for continued stay if applicable
- Other supporting material appropriate to include
- For non-mental 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. In addition, Humana Healthy Horizons in South Carolina requires that members or their representatives are entitled to a copy of the member's medical 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 OB-GYNs 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 South Carolina, 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 South Carolina upon request. Information from the health records review may be used in the re-credentialing process as well as quality activities.

External quality reviews

SCDHHS may retain an external quality review organization (EQRO) to conduct medical record reviews for Humana Healthy Horizons members. Participating providers are expected to partner with Humana Healthy Horizons on any EQRO activities. Humana Healthy Horizons participates and cooperates in an annual external quality review in accordance with 42 CFR § 438.204. The review includes, but not be limited to, review of quality outcomes, timeliness of, and access to, the services covered under the contract.

Patient safety to include quality of care and quality of service

Humana Healthy Horizons 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 also is 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 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 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 also may be requested when investigating complaints of poor quality or service or clinical outcomes. Your contract with Humana Healthy Horizons 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 guidelines. The record reviewers protect member information from unauthorized disclosure as set forth in the contract and ensures all HIPAA guidelines are enforced.
- Performance measures – Data collected on patient outcomes as defined by HEDIS or otherwise defined by the agency.
- Surveys – CAHPS, provider satisfaction, behavioral health surveys, and special surveys to support quality/ performance improvement initiatives.
- Peer Review – Review of provider's practice methods and patterns to determine appropriateness of care.

Web resources

Humana Healthy Horizons periodically updates clinical, coverage and preventive guidelines, as well as other resource documents, posted on the Humana website. Please check the website frequently for the latest news and updated documents at Humana.com/HealthySC.

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 and SCDHHS 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 will be kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Humana ensures no retaliation against callers as 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**) and SCDHHS at **888-364-3224**.

In addition, providers may 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

Credentialing and Re-credentialing

Humana conducts credentialing and re-credentialing activities using the guidelines established by SCDHHS, CMS and NCQA. Humana credentials and re-credentials all licensed independent practitioners with whom it contracts and who fall within its scope of authority and action, including physicians, facilities and non-physicians. Through credentialing, Humana verifies the qualifications and performance of physicians and other healthcare practitioners. A senior clinical staff person is responsible for oversight of the credentialing and re-credentialing program. On SCDHHS selection and implementation of a credentials verification organization (CVO), Humana accepts the credentialing and re-credentialing decisions of the of the CVO's credentials committee for our South Carolina Medicaid Health Connections core provider network.

All providers requiring credentialing should complete the credentialing process prior to the provider's contract effective date, except where required by state regulations.

Additionally, a provider appears in the provider directory once credentialing is complete.

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

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

Practitioner credentialing and re-credentialing

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

- Medical and osteopathic physicians
- Oral surgeons
- Chiropractors
- Podiatrists
- Dentists
- Optometrists
- Allied health providers, including, advanced practice registered nurse practitioners (APRN), clinical nurse specialists and certified nurse midwives and physician assistants
- Physical and occupational therapists
- Audiologists
- Speech/language therapists/pathologists
- Other licensed or certified practitioners, including physician extenders, who act as a primary care provider or those that appear in the provider directory

Behavioral health practitioners:

- Psychiatrists and other physicians
- Addition medicine specialists
- Doctorial or master's level psychologists who are state certified or licensed
- Master's level clinical social workers who are state certified or licensed
- Master's level marriage and family therapists
- Master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed
- Other behavioral health specialists who are licensed, certified or registered by the state to practice independently

CAQH application

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

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

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

- Current malpractice insurance face sheet
- A current Drug Enforcement Administration (DEA) certificate
  - All buprenorphine prescribers must have an "X" DEA number
- Explanation of any lapse in work history of six months or greater
- Clinical Laboratory Improvement Amendment (CLIA) certificate, as applicable
  - Copy of current Collaborative Practice Agreement between an advanced practice registered nurse, physician assistant, certified nurse midwife or osteopathic assistant and supervising practitioner.
- Education Council for Medical Graduates (ECFMG), if foreign medical degree

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

Practitioner credentialing and re-credentialing access

The following elements used to assess practitioners for credentialing and re-credentialing include:

- Signed and dated credentialing application, including supporting documents
- Active and unrestricted license in the practicing state issued by the appropriate licensing board and is enrolled with SCDHHS as a qualified Medicaid provider.
- Previous five-year work history
- Current Drug Enforcement Administration (DEA) certificate and/or state narcotics registration, as applicable
- Education, training and experience are current and appropriate to the scope of practice requested
- Successful completion of all training programs pertinent to one's practice
- For M.D.s and D.O.s, successful completion of residency training pertinent to the requested practice type
- For dentists and other providers where special training

is required or expected for services being requested, successful completion of training program
- Board certification, as applicable
- Current malpractice insurance coverage at the minimum amount in accordance with South Carolina laws
- In good standing with:
  - Medicaid agencies
  - Medicare program
- Health and Human Services-Office of Inspector General (HHS-OIG)
- General Services Administration (GSA, formerly EPLS)
- Active and valid South Carolina Medicaid ID number
- Active hospital privileges, as applicable
- NPI, as verifiable via the National Plan and Provider Enumerator System (NPPES)
- Quality-of-care and practice history as judged by:
  - Medical malpractice history
  - Hospital medical staff performance
- Licensure or specialty board actions or other disciplinary actions, medical or civil
- Lack of member grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall member satisfaction
- Other quality-of-care measurements/activities
- Allied health providers, including nurse practitioners (NPs), physician assistants (PAs), certified nurse midwives (CNMs), osteopathic assistants (OAs), are required to provide evidence that a formal relationship exists with a Humana participating supervising physician through collaborative agreement. Such collaborative agreement must include established admitting arrangements to a Humana-participating facility.

Organizational credentialing and re-credentialing

Organizational providers, defined as hospitals or other healthcare facilities, are assessed during credentialing and re-credentialing according, but not limited to, the following elements:
- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free standing ambulatory surgery centers
- Hospice providers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting
- Dialysis centers
- Physical, occupational therapy and speech language pathology (PT/OT/SLP) facilities
- Rehabilitation hospitals (including outpatient locations)
- Diabetes education
- Portable X-ray suppliers
- Rural health clinics and federally qualified health centers
- School-based health clinics

The following elements are assessed for organizational providers:
- Organization is in good standing with:
  - Medicaid agencies and enrolled with SCDHHS as a Qualified Medicaid Provider
  - Medicare program
- Health & Human Services - Office of Inspector General (HHS-OIG)
- General Services Administration (GSA, formerly EPLS)
- Organization has been reviewed and approved by an accrediting body
- Copy of facility's state license, as applicable
- CLIA certificates are current, as applicable
- Completion of a signed and dated application
- Organization will be informed of the credentialing committee's decision within 60 business days of the committee meeting
- Organizational provider are reassessed at least every 3 years
- Inpatient/outpatient hospital providers, ambulatory surgical center providers, and end-stage renal disease clinic providers supply evidence that a survey was completed by the Department of Health and Environmental Control (DHEC) and is certified by CMS
- Federally qualified health clinics (FQHC) supply evidence of Notice of Grant Award under 319, 330 or 340 of the Public Health Services Act. FQHC providers are required to be certified by CMS. FQHCs providing laboratory services must supply a CLIA certificate at credentialing and re-credentialing
- Rural health clinic (RHCs) providers are licensed by DHEC. RHC providers must be certified by CMS. RHCs providing laboratory services must supply a CLIA certificate at credentialing and re-credentialing.
- Alcohol and substance use clinics are licensed by DHEC
- Portable X-ray providers be surveyed by DHEC. Portable X-ray providers are required to be certified by CMS
- Stationary X-ray equipment be registered with DHEC
- Physiology lab providers to be enrolled with Medicare
- Mammography service facilities providers be certified by the Food and Drug Administration (FDA)
- Mail order pharmacies are licensed by the appropriate state board. Out of state mail order pharmacy providers are required to have a non-resident South Carolina permit issued by the South Carolina Board of Pharmacy

- Home health service providers to be licensed and surveyed by the DHEC. Home health service providers must be certified by CMS
- Long-term care facilities/nursing homes be surveyed and licensed under state law. Long-term care facilities/nursing homes are required to be certified by DHEC
- All South Carolina agencies and organizations rather than each individual provider employed at the agency/organization. Such agencies and organizations include: Department of Alcohol and Other Drug Abuse, Department of Mental Health, the Department of Social Services, the Department of Health and Environmental Control, local education agencies, rehabilitative behavioral health providers (public and private) and the Department of Disabilities and Special Needs.

Provider re-credentialing

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

Practitioner rights

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

Provider responsibilities

Network providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. All providers must be enrolled as a Qualified Medicaid Provider with SCDHHS. Humana initiates immediate action in the event that the participation criteria are no longer met. Network providers are required to inform Humana of changes in status, including but not limited to, being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure or board certification, an event reportable to the National Practitioner Data Bank (NPDB), federal, state or local sanctions, or complaints.

Delegation of credentialing/re-credentialing

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

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

Subcontractors (delegate) must be in good standing with Medicaid and CMS. Reporting is required from the subcontractor, which is defined in an agreement between both parties.

Reconsideration of credentialing/re-credentialing decisions

Humana's Credentials Committee may deny a provider's request for participation based on credentialing criteria. The Credentials Committee must notify a provider of a denial that is based on credentialing criteria and provide the opportunity to request reconsideration of the decision within 30 days of the notification. Reconsideration opportunities are available to a provider if he or she is affected by an adverse determination. To submit a reconsideration request, the following steps apply:

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

Humana Healthy Horizons in South Carolina
Attn: Ayo Gathing
101 E. Main St.
Louisville, KY 40202

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

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

Delegated Services, Policies and Procedures

Scope

The guidelines and responsibilities outlined in this appendix are applicable to all Humana subcontractors (delegate). The policies in Humana's Provider Manual for Physicians, Hospitals and Other Healthcare Providers (manual) , found at https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=5028868, also apply to subcontractors.

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

Overview

Humana may enter into a written agreement with another legal entity to delegate the authority to perform certain functions on its behalf, such as:

- Credentialing of physicians, facilities and other healthcare providers
- Provision of clinical health services, such as utilization management and population health management
- Claims adjudication and payment
- Inquiries in the medical and managed behavioral healthcare organization (MBHO) setting

Contact the local Humana market office provider representative for detailed information on delegation, or call Provider Relations at **800-626-2741**.

Subcontractors must comply with the responsibilities outlined in the Delegated Services, Policies and Procedures section of this manual. The document is available here, from the local Humana market office, or by calling **800-626-2741**.

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 remains responsible for the performance and compliance of any function that is delegated, Humana provides oversight of the subcontractor.

Oversight is the formal process through which Humana performs auditing and monitoring of the subcontractor's:

- Ability to perform the delegated function(s) on an ongoing basis
- Compliance with accreditation organization standards, state and federal rules, laws and regulations, Humana policies and procedures, as well as their underlying contractual requirements pertaining to the provision of healthcare services and
- Financial soundness (if delegated for claims adjudication and payment).

The delegation process begins with Humana performing a pre-delegation audit prior to any function being delegated to a prospective subcontractor. After approval and execution of a delegation agreement, Humana performs an annual audit on an ongoing basis until the delegation agreement is terminated. At a minimum, these audits include a review of the applicable documents listed below:

- Policies and procedures
- Program descriptions and work plans
- Forms, tools and reports
- Sub-delegation agreement(s)
- Audit(s) of 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 continues to monitor all subcontractors through the collection of periodic reporting outlined within the delegation agreement. Humana provides the templates and submission process for each report. In addition, reporting requirements may change to comply with NCQA accreditation, state and federal rules, laws and regulations and/or Humana standards. Any changes are communicated to the subcontractor at such time.

Corrective action plans

Failure of a subcontractors to adequately perform any of the delegated functions in accordance with Humana requirements, federal and state laws, rules and regulations, or NCQA accreditation organization standards,

may result in a written corrective action plan (CAP). The subcontractor provides a written response describing how they meet the requirements in which they were found to be noncompliant, including the expected remediation date of compliance. Humana cooperates with the subcontractor throughout the remediation of all identified failures. If a subcontractor does not comply with its contractual requirements or this manual, or any request by Humana to comply with the remediation of a CAP, may result, at Humana'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 subcontractor must comply with the following requirements:

- Submit any material change in the performance of delegated functions to Humana 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's record retention policy for all delegated function documents, which is 10 years (the same as the CMS requirement).
- Comply with requirements to issue member denial and approval letters in the member's preferred language as required by Section 30.3 of the Marketing Guidance for South Carolina Medicare-Medicaid Plans.

Sub-delegation

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

In addition, Humana 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 approves the sub-delegation, the delegate will provides Humana 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 access to all records and documentation pertaining to monitoring and oversight of the delegated activities.
- Requires the delegated functions to be performed in accordance with Humana and subcontractor's requirements, state and federal rules, laws and regulations and NCQA accreditation organization standards and subject to the terms of the written agreement between Humana and the subcontractor.
- Retains Humana's right to perform evaluation and oversight of the subcontractor.

The subcontractor is responsible for providing adequate oversight of any entity it sub-delegates to, including any other downstream entities. The subcontractor must provide Humana with documentation of such oversight prior to delegation and annually thereafter. Humana retains the right to perform additional evaluation and oversight of the subcontractor, if deemed necessary by Humana. Furthermore, Humana retains the right to modify, rescind or terminate, at any time, any one or all delegated activities, regardless of any sub-delegation that may previously have been approved.

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

Appeals and grievances

Humana member appeals/grievances and expedited appeals are not delegated, including any appeal made by

a physician/provider on behalf of the member. Humana maintains all member rights and responsibility functions except in certain special circumstances. Therefore, the subcontractor must:

- Forward all standard member appeals/grievances to Humana within one business day by calling **866-432-0001** or faxing the appeal/grievance to **800-949-2961**.
- Forward all expedited appeals immediately on notification/receipt by calling **866-432-0001** or faxing the expedited appeal to **800-949-2961**. When faxing, the subcontractor provides 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 and support any requests received from Humana in an expedited manner.
- Handle physician, provider, hospital and other healthcare professional and/or participating provider claim payment and denial complaints or claim contestations and provider appeals regarding termination of the agreement.
- Refer to your delegation agreement for how to handle all non-participating provider appeals for claims payment and denials.

Utilization Management Delegation

Delegation of utilization management (UM) is the process by which the subcontractor 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: Subcontractor is to conduct the following functions regarding initial determination for inpatient and SNF stays:

- Maintain policies and procedures that address all aspects of the UM process including a member's right to a second opinion. Policies and procedures must be formally reviewed, revised, dated and signed annually. Effective dates are present on policies or on a policy master list.
- Perform preadmission review and authorization, including medical necessity determinations based on approved criteria, specific benefits and member eligibility. In full-risk arrangements, Humana performs this function when review decisions by a delegate are not timely, are contrary to medical necessity criteria and/or when Humana must resolve a disagreement between a delegate, providers and a member. In some local health plans, Humana may assume total responsibility for this function. Refer to your delegation agreement for specifics.
- Expedite determinations (as required) and maintain an expedited determinations log. Submit log as required by regulatory and accreditation organization standards. In full-risk arrangements, Humana performs this function when review decisions by delegate are not timely, are contrary to medical necessity criteria and/or when Humana must resolve a disagreement between delegate, providers and member. In some local health plans, Humana may assume total responsibility for this function. Refer to your delegation agreement for specifics.
- Agree not to have a more stringent preauthorization and notification list than Humana's, which is posted on Humana.com.
- Notify member, facility and provider of decision on initial determination. For adverse determinations, maintain denial log and submit as required by regulatory and accreditation organization requirements. Humana retains the right to make the final decision regardless of contract type.

The subcontractor is to perform the following concurrent review activities relevant to inpatient and SNF stays:

- 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 does not delegate quality-of-care determinations.
- Provide continued stay determinations and maintain a denial log for submission to Humana as directed. Humana retains the right to make the final decision in all contract arrangements. Refer to your delegation agreement, for specifics.
- Notify member, facility and provider of decision on concurrent determination. For adverse determinations, maintain denial log and submit as required by regulatory and accreditation organization requirements. Humana retains the right to make the final decision regardless of contract type.
- The subcontractor is to perform discharge planning and retrospective review activities related to inpatient and SNF stays. The subcontractor is to conduct retrospective review functions as related to ambulatory care.

Claims delegation

Claims delegation is a formal process by which a health plan gives a participating provider (delegate) the authority to process claims on its behalf. Humana'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 retains the right and final authority to pay any claims for its members regardless of any delegation of such functions or activities to subcontractor. Amounts authorized for payment by Humana of such claims may be charged against subcontractor's funding. Refer to contract for funding arrangement details.

Claims performance requirements: All delegates performing claims processing comply with and meet the rules and requirements for the processing of Medicaid claims established or implemented by the state.

In addition, they must conduct claims adjudication and processing in accordance with the member's plan and Humana's policies and procedures. The delegate needs to meet, at a minimum, the following claims adjudication and processing requirements:

- Subcontractor 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 which Humana is subject.
- Subcontractor must meet applicable state and/or federal requirements to which Humana is subject for denial and appeals language in all communications made to members and use Humana's member letter template.
- Since Humana does not delegate nonparticipating provider reconsideration requests, delegate should forward all requests to Humana upon receipt.
- Subcontractor shall provide a financial guarantee, acceptable to Humana, 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.
- Subcontractor shall supply staff and systems required to provide claims and encounter data to Humana as required by state and federal rules, regulations and Humana. Refer to the Process Integration Agreement for details.
- Subcontractor should use and maintain a claims processing system that meets current legal, professional and regulatory requirements.
- Subcontractor should print its name and logo on applicable written communications including letters or other documents related to adjudication or adjustment of member benefits and medical claims.

Credentialing delegation

The subcontractor is to comply with Humana's credentialing and re-credentialing requirements, all applicable state and federal laws, rules and regulations and NCQA Standards and Guidelines for the Accreditation of Medicaid Managed Care Organizations requirements pertaining to credentialing and/or re-credentialing. This includes maintaining a credentialing committee, a credentialing and re-credentialing program and all related policies, procedures and processes in compliance with these requirements.

Humana is responsible for the collection and evaluation of ongoing monitoring of sanctions and complaints. In addition, Humana retains the right to approve, deny, terminate or suspend new or renewing practitioners and organizational providers from participation in any of delegator's networks.

Reporting requirements: Complete listings of all participating providers credentialed and/or re-credentialed are due on a semiannual basis or more frequently if required by state law. In addition, delegate should submit reports to Humana of all credentialing approvals and denials within 30 days of the final credentialing decision date. Delegate should include, at a minimum, the below elements in its credentialing reports to Humana:

- Practitioner
- Degree
- Practicing specialty
- NPI
- Initial credentialing date
- Last re-credentialing date
- Specialist/hospitalist indicator
- State of practice
- License
- Medicare/Medicaid number
- Active hospital privileges (if applicable)

Definitions

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes Beneficiary practices that result in unnecessary cost to the Medicaid Program.

Action – The denial or limited authorization of a requested service, including the type or level of service.

Administrative days – Inpatient hospital days associated with nursing home level patients who no longer require acute care and are waiting for nursing home placement. administrative days must follow an acute inpatient stay.

Adverse benefit determination – An adverse benefit determination is:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service.

(4) The failure to provide services in a timely manner, as defined by the state.

(5) The failure of an MCO, PIHP, or PAHP to act within the time frames provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(6) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.

(7) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Ambulance services – Ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary's health (42 CFR §422.113(a)).

Appeal – A request for review of an adverse benefit determination, as defined in 42 C.F.R. § 438.400.

Authorized representative – An authorized representative is an individual granted authority to act on a member's behalf through a written document signed by the applicant or member, or through another legally binding format subject to applicable authentication and data security standards. Legal documentation of authority to act on behalf of an applicant or member under state law, such as a court order establishing legal guardianship or a power of attorney, serves in place of the applicant's or member's signature.

Behavioral health – A state of health that encompasses mental, emotional, cognitive, social, behavioral stability including freedom from substance use disorders.

Behavioral health provider – Individuals and/or entities that provide behavioral health services.

Behavioral health services – The blending of mental health disorders and/or substance use disorders prevention in treatment for the purpose of providing comprehensive services.

Benefit or benefits – The health care services set forth in this contract, for which Humana has agreed to provide, arrange, and be held fiscally responsible. Also referenced as core benefits or covered services.

Business days – Monday through Friday from 9 a.m. to 5 p.m., excluding state holidays.

Calendar days – All seven days of the week (i.e., Monday, Tuesday, Wednesday, Thursday, Friday, Saturday and Sunday).

Care coordination – The manner or practice of planning, directing and coordinating health care needs and services of Medicaid managed care program members.

Care coordinator – The individual responsible for planning, directing and coordinating services to meet identified health care needs of Medicaid managed care program members.

Care management – Care management is a set of activities designed to assist patients and their support systems in managing medical conditions and related psychosocial problems more effectively, with the aims of improving patients' functional health status, enhancing coordination of care, eliminating duplication of services and reducing the need for expensive medical services (NCQA).

Case – An event or situation.

Case management – A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes (CMSA, n.d.)

Case manager – The individual responsible for identifying and coordinating services necessary to meet service needs of Medicaid managed care program members.

Claim – A bill for services, a line item of services, or all services for one recipient within a bill.

Clean claim – Claims that can be processed without obtaining additional information from the provider of the service or from a third party.

Copayment – Any cost-sharing payment for which the Medicaid managed care program member is responsible.

Covered services – Services included in the South Carolina State Plan for Medical Assistance and covered under Humana. Also referred to as benefits or covered benefits.

Credentialing – Humana's determination as to the qualifications and ascribed privileges of a specific provider to render specific health care services.

Credible allegation of fraud – A credible allegation of fraud may be an allegation, which has been verified by the state. Allegations are considered to be credible when they have indications of reliability and the state Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. Sources include, but are not limited to, the following:

- Fraud hotline complaints.
- Claims data mining.
- Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Cultural competency – A set of interpersonal skills that promote the delivery of services in a culturally competent manner to all Medicaid managed care members—including those with limited English proficiency and diverse cultural and ethnic backgrounds—allowing for individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Medicaid managed care members (as required by 42 CFR §438.206).

Disenroll/disenrollment/disenrolled – Action taken by department or its designee to remove a Medicaid managed care program member from the a plan following the receipt and approval of a written request for disenrollment or a determination made by department or its designee that the member is no longer eligible for Medicaid or the Medicaid managed care program.

Dual diagnosis or dual disorders – An individual who has a diagnosed mental health problem and a problem with alcohol and/or drug use.

Dual eligible (a.k.a. Dual Eligibles) – Individuals who are enrolled in Medicaid and Medicare programs and receive benefits from both programs.

Eligible or eligibles – A person who has been determined eligible to receive services as provided for in the South Carolina State Plan for Medical Assistance under Title XIX.

Emergency medical condition – Medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy; serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency services – Covered inpatient and outpatient services that are as follows:

- Furnished by a provider that is qualified to furnish these services under this title; and
- Needed to evaluate or stabilize an emergency medical condition.

Encounter – Any service provided to a Medicaid managed care program member regardless of how the service was reimbursed and regardless of provider type, practice specialty, or place of services. This would include expanded services/benefits as defined in this contract.

Enrollment – The process in which a Medicaid-eligible applicant selects or is assigned to Humana and goes through a managed care educational process as provided by the department or its agent.

Enrollment (voluntary) – The process in which an applicant/recipient selects Humana and goes through an educational process to become a Medicaid managed care program member of Humana.

Evidence of coverage – The term which describes services and supplies provided to Medicaid managed care program members, which includes specific information on benefits, coverage limitations and services not covered. The term "Evidence of Coverage" is interchangeable with the term "Certificate of Coverage."

Excluded services – Medicaid services not included in the core benefits and reimbursed fee-for-service by the state.

Exclusion – Items or services furnished by a specific provider who has defrauded or abused the Medicaid program is not reimbursed under Medicaid.

Family planning services – Services that include examinations and assessments, diagnostic procedures, health education, and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics and pharmacies.

Fee-for-Service (FFS) Medicaid Rate – A method of making payment for healthcare services based on the current Medicaid fee schedule.

Fraud – In accordance with § 42 CFR 455.2 definitions, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes under applicable federal or state law.

Fraud, waste and abuse (FWA) – FWA is the collective acronym for the terms Fraud, Waste and Abuse.

Geographic service area – Each of the 46 counties that comprise the state of South Carolina.

Grievance – Means an expression of dissatisfaction about any matter other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the member's rights.

Grievance system – Refers to the overall system that includes grievances and appeals processes and Medicaid managed care member access to state fair hearings.

High-risk member – High-risk members do not meet low- or moderate-risk criteria.

Home and community based services (HCBS) – In-home or community-based support services that assist persons with long term care needs to remain at home as authorized in an approved 1915(c) Waiver or 1915(i) State Plan.

Hospital swing beds – Hospitals participating in both the Medicaid and Medicare programs, in addition to providing an inpatient hospital level of care, also may provide nursing-facility-levels of care and be reimbursed as "swing bed" hospitals. A swing bed hospital must be located in a rural area, have fewer than 100 inpatient beds, exclusive of newborn and intensive care type beds, and be surveyed for compliance by DHEC and certified as meeting federal and state requirements of participation for swing bed hospitals.

Improper payment – Any payment that is made in error or in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements;

- To an ineligible recipient,
- For ineligible goods or services,
- For goods or services not received (except for such payments where authorized by law),
- That duplicates a payment, or
- That does not account for credit for applicable discounts.

Inquiry – A routine question/s about a benefit. An inquiry does not automatically invoke a plan sponsor's grievance or coverage determination process.

Intensive case management (ICM) – For the purposes of this contract, ICM refers to:

- A more intensive type of intervention in comparison to a standard or traditional case management/disease management program where the activities used help ensure the patient can reach his/her care goals.
- A more frequent level of interaction – direct and indirect contact, more time spent – with the Medicaid managed care member. This may include the use of special technology and/or devices, such as telemonitoring devices.

List of Excluded Individuals/Entities (LEIE) – The Office of Inspector General (OIG) of the U.S. Department of Health and Humana Services maintains the LEIE, a database accessible to the public that provides information about parties excluded from Medicare, Medicaid and all other federal health care programs. The LEIE website is available in two formats:

- The on-line search engine (located at exclusions.oig.hhs.gov) identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match by entering the Social Security number (SSN) or employer identification number (EIN).
- The downloadable version of the database, located at www.oig.hhs.gov/exclusions/exclusions_list.asp, may be compared against an existing database maintained by the provider; however, the downloadable version does not contain SSNs or EINs. Instead, those identifiers may be entered in the searchable database within the OIG site, as referenced in the first bullet.

Low-risk member – Low-risk members do not meet moderate- or high-risk criteria.

Medicaid Fraud Control Unit (MFCU) – The division of the state attorney general's office responsible for the investigation and prosecution of provider fraud.

Medicaid Integrity Program (MIP) – A program enacted by the Deficit Reduction Act (DRA) of 2005 signed into law in February 2006 that created the Medicaid Integrity Program (MIP) under Section 1936 of the Social Security Act, under which CMS hires contractors to review Medicaid provider

activities, audit claims, identify overpayments and to support and provide effective assistance to states in their efforts to combat Medicaid provider fraud and abuse.

Medicaid Recipient Fraud Unit (MRFU) – The division of the state attorney general's office responsible for the investigation and prosecution of recipient fraud.

Medicaid Recovery Audit Contractor Program – Administered by the state agency to identify overpayments and underpayments and recoup overpayments.

Medical necessity – Medically necessary services are those services utilized in the state Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in state statutes and regulations, the state plan, and other state policy and procedures.

Member – A Medicaid beneficiary who is currently enrolled in the state's Medicaid managed care program, specifically a managed care organization (MCO). Other managed care programs may include, but are not limited to PIHP, PAHP, or PCCM (42 CFR §438.10 (a)).

Member incentive – Incentives to encourage a Medicaid managed care member to change or modify behaviors or meet certain goals.

Member or Medicaid Managed Care member – An eligible person who is currently enrolled with a department-approved Medicaid managed care contractor. Throughout this contract, this term is used interchangeably with "member" and "beneficiary".

Moderate-risk member – Moderate-risk members do not meet low- or high-risk criteria.

Non-covered services – Services not covered under the South Carolina State Plan for Medical Assistance.

Non-participating provider physician – A physician licensed to practice who has not contracted with or is not employed by Humana to provide healthcare services.

Outpatient services – Preventive, diagnostic, therapeutic, rehabilitative, surgical, mental health, facility services for dental, and emergency services received by a patient through an outpatient/ambulatory care facility for the treatment of a disease or injury for a period of time generally not exceeding 24 hours.

Overpayment – The amount paid by Humana to a provider, which is in excess of the amount that is allowable for services furnished under Section 1902 of the Act, or to which the provider is not entitled and which is required to be refunded under Section 1903 of the Act.

Policies – The general principles by which the department is guided in its management of the Title XIX Program, as further defined by department promulgations and state and federal rules and regulations.

Prevalent non-english language – A non-English language determined to be spoken by a significant number or percentage of potential members and members who are limited English proficient

Primary care provider (PCP) – A general practitioner, family physician, internal medicine physician, obstetrician-gynecologist, or pediatrician who serves as the entry point into the healthcare system for the member. The PCP is responsible for providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining continuity of care.

Prior authorization – The act of obtaining authorization from Humana for specific services before rendering those services.

Procedure – For the purposes of this contract, procedure is defined as:

- An act or a manner of proceeding in an action or process;
- Any acceptable and appropriate mode of conducting all or a portion of work—the individual or collective tasks or activities.

Protected health information (PHI) – Protected health information as defined in 45 CFR §160.103

Provider – In accordance with 42 CFR § 400.203 definitions specific to Medicaid, any individual or entity furnishing Medicaid services under a provider agreement with Humana or the Medicaid agency.

Quality assessment and performance improvement (QAPI) – Activities aimed at improving in the quality of care provided to members through established quality management and performance improvement processes

Recipient – A person who is determined eligible to receive services as provided for in the South Carolina State Plan for Medical Assistance.

Recoupment – The recovery by, or on behalf of, either the state agency or Humana of any outstanding Medicaid debt.

Redetermination – A person who was determined eligible to receive services as provided for in the South Carolina State Plan for Medical Assistance under Title XIX after formerly not being eligible under the South Carolina State Plan for Medical Assistance under Title XIX.

Rural health clinic (RHC) – A South Carolina licensed rural health clinic is certified by CMS and receives public health services grants. A RHC eligible for state-defined cost-based reimbursement from the Medicaid fee-for-service

program. A RHC provides a wide range of primary care and enhanced services in a medically underserved area.

South Carolina Department of Health and Human Services (SCDHHS) – SCDHHS and "department" are interchangeable terms and definitions they are one in the same and one maybe be used to define the other in this document as well as in the MCO contract.

South Carolina Healthy Connections Choices – South Carolina Medicaid's contracted enrollment broker for managed care members.

South Carolina Healthy Connections Medicaid – The Title XIX program administered by the department, also known as South Carolina Medicaid.

Special populations – Individuals who may require additional healthcare services that should be incorporated into a care management plan that guarantees that the most appropriate level of care is provided for these individuals.

Suspension of payment for credible allegation – In accordance with § 42 CFR 455.23, suspension of payment in cases of fraud, means that all Medicaid payments to a provider are suspended after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.

System for Award Management (SAM) – The U.S. General Services Administration maintains the SAM, a database accessible to the public that provides information about parties excluded from Medicare, Medicaid and all other federal healthcare programs. The SAM website is available in two formats:

- The on-line search engine, available at https://sam.gov/reports/awards/standard, identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match by entering the SSN or EIN.
- The downloadable version of the database, available at www.sam.gov/SAM, may be compared against an existing database maintained by the provider; however, the downloadable version does not contain SSNs or EINs. Instead, those identifiers may be entered in the searchable database within the SAM site, as referenced in the first bullet.

Targeted case management (TCM) – Services that assist individuals in gaining access to needed medical, social, educational, and other services as authorized under the state plan. Services include a systematic referral process to providers.

UB-04 – A uniform bill for inpatient and outpatient hospital billing. The required form is the UB-04 CMS 1500.

Validation – The review of information, data and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Waste – The unintentional misuse of Medicaid funds through inadvertent error that most frequently occurs as incorrect coding and billing.

Abbreviations

AAP ..... American Academy of Pediatrics

AAPC..... American Academy of Professional Coders

ACA ..... Patient Protection and Affordable Care Act

ACD..... Automated Call Distribution System

ACIP ..... Advisory Committee on Immunization Practices

ACR ..... Average Commercial Rate

ADA..... Americans with Disabilities Act

ADL ..... Activities of Daily Living

AHIMA ..... American Health Information Management Association

AHRQ ..... Agency for Healthcare Research and Quality

Ann. ..... Annotated

ANSI ..... American National Standards Institute

APM..... Alternative Payment Model

ASAM ..... American Society for Addiction Medicine

ASC ..... Accredited Standards Committee

BEOMB ..... Beneficiary Explanation of Benefits

CAHPS..... Consumer Assessment of Healthcare Providers and Systems

CAP ..... Corrective Action Plan

CCN..... Claim Control Number

CCS-P® ..... Certified Coding Specialist — Physician-Based

CDC..... Centers for Disease Control

CEO ..... Chief Executive Officer

CER..... Comparative Effectiveness Review

CFO ..... Chief Financial Officer

CFR..... Code of Federal Regulation

CHCA..... Certified in HEDIS Compliance Auditor

CHCQM..... Certified in Health Care Quality and Management

CHIP ..... Children's Health Insurance Program

CLIA..... Clinical Laboratory Improvement Amendments

CLTC..... Community Long-term Care

CMS ..... Centers for Medicare & Medicaid Services

CMSA ..... Case Management Society of America

COO ..... Chief Operating Officer

CPHQ ..... Certified Professional in Health Care Quality

CPT..... Current Procedural Terminology

EQI ..... Encounter Quality Initiative

CY..... Calendar Year

DAODAS.... Department of Alcohol and Other Drug Abuse Services

DHHS..... United States Department of Health and Human Services

DME.....Durable Medical Equipment

DSH ..... Disproportionate Share Hospitals

DRA..... Deficit Reduction Act

DRG..... Diagnosis-Related Group

DOT..... Directly Observed Therapy

DUR..... Drug Utilization Review

EPSDT ..... Early and Periodic Screening, Diagnosis and Treatment

EPHI ..... Electronic Protected Health Information

EQR..... External Quality Review

EQRO ..... External Quality Review Organization

ESRD ..... End-stage Renal Disease

Et Seq..... meaning “and the following”

FAR ..... Final Audit Report

FDA ..... Food and Drug Administration

FFP ..... Federal Financial Participation

FFS ..... Fee-for-service

FMAP ..... Federal Medical Assistance Percentages

FPL ..... Federal Poverty Level

FQHC..... Federally Qualified Health Center

FTE ..... Full-time Equivalent

FWA ..... Fraud, Waste and Abuse

FY..... Fiscal Year

GAO ..... S. General Accounting Office or Accountability Office

GME..... Graduate Medical Education

H.R ..... House of Representatives

HAC..... Hospital Acquired Conditions

HCBS ..... Home and Community-Based Services

HCPCS ..... Healthcare Common Procedure Coding System

HHS..... Health and Human Services

HIV/AIDS... Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome

HEDIS® ..... Healthcare Effectiveness Data and Information Set

HIPAA .....Health Insurance Portability and Accountability Act of 1996

HIT .....Health Insurance Tax (a.k.a. Health Insurance Fee)

HITECH .....Health Information Technology for Economic and Clinical Health Act

HMO .....Health Maintenance Organization

ICM ..... Intensive Case Management

ICF/IID..... Intermediate Care Facility for Individuals with Intellectual Disabilities

ID ..... Identification Number

IDSS..... Interactive Data Submission System

IMD..... Institute for Mental Disease

IP..... In-patient (Hospital)

IVR ..... Interactive Voice Response

LEA..... Local Education Authorities

LEIE ..... List of Excluded Individuals/Entities

LIP..... Licensed Independent Practitioner

LIS ..... Low-income Subsidy

LISW..... Licensed Independent Social Worker

LPHA ..... Licensed Practitioner of the Healing Arts

LTC..... Long-term Care

LTSS ..... Long-term Services and Supports

NAIC..... National Association of Insurance Commissioners

MA..... Medicare Advantage Plan

MCAC..... Medical Care Advisory Committee

MCO..... Managed Care Organization

MCE ..... Managed Care Entity

MFCU..... Medicaid Fraud Control Unit

MHPAEA ... Mental Health Parity and Addiction Equity Act of 2008

MI ..... Mental Illness

MIC ..... Medicaid Integrity Audit Contractor

MIP ..... Medicaid Integrity Program

MLR..... Medical Loss Ratio

MLTSS ..... Managed Long-term Services and Supports

MMA..... Medicare Prescription Drug, Improvement, and Modernization Act of 2003

MMIS ..... Medicaid Management Information System

MOA ..... Memorandum of Agreement

MOU ..... Memorandum of Understanding

MPS ..... Minimum Performance Standards

MRFU..... Medicaid Recipient Fraud Unit

MSP ..... Minimum Subcontract Provision

NAHQ..... National Association for Healthcare Quality

NCCI ..... National Correct Coding Initiative

NCPDP ..... National Council for Prescription Drug Program

NCQA ..... National Committee for Quality Assurance

NDC..... National Drug Code

No. ..... Number

NP ..... Nurse Practitioner

NPI ..... National Provider Identification Number

NPDB..... National Practitioner Database

OB-GYN..... Obstetrics - Gynecology

OIG..... Office of Inspector General

OP ..... OutPatient (Hospital)

OPAC..... Outpatient Pediatric AIDS Clinic

P.L. ..... Public Law

P&T ..... Pharmacy & Therapeutics Committee

PAHP..... Prepaid Ambulatory Health Plan

PASARR..... Preadmission Screening and Resident Review

PBM ..... Pharmacy Benefits Manager

PCAT ..... Payment Category

PCCM..... Primary Care Case Management

PCP ..... Primary Care Physician

PDP ..... Prescription Drug Plan

PHI ..... Protected Health Information

PI..... Program Integrity

PIHP ..... Prepaid Inpatient Health Plan

PIP..... Performance Improvement Project

PMPM..... Per Member (Member) Per Month

PPC ..... Provider Preventable Conditions

PPS..... Prospective Payment System

PRTF..... Psychiatric Residential Treatment Facilities Demonstration

QA..... Quality Assessment

QAP..... Quality Assessment Program

QAPI..... Quality Assessment and Performance Improvement

QI.....Qualifying Improvement

QIO ..... Quality Improvement Organization

RAC ..... Medicaid Recovery Audit Contractor

Regs ..... Regulations

RHC..... Rural Health Center

RN..... Registered Nurse

Rx..... Prescription Drugs

SA ..... Service Authorization

SAM ..... System for Award Management

SC or S.C.... South Carolina

SCAG..... South Carolina Office of the Attorney General

SCDHEC..... South Carolina Department of Health and Environmental Control

SCDHHS .... South Carolina Department of Health and Human Services

SCDOI. .....SC Department of Insurance

SCDOR ..... South Carolina Department of Revenue

SCHCC..... South Carolina Healthy Connections Choices

SFY ..... State Fiscal Year

SIU ..... Special Investigation Unit

SLA..... Service Level Agreement

SPA ..... State Plan Amendment

SPMI ..... Serious and Persistent Mental Illness

SPLIP..... Statewide Pharmacy Lock-In Program

SSDMF ..... Social Security Administration Death Master File

SSA..... Social Security Administration

SSI..... Supplemental Security Income

Stat ..... Statute

STD ..... Sexually Transmitted Disease

STP..... Supplemental Teaching Payment

Supp..... Supplement

SUD..... Substance Use Disorder

SUR ..... Surveillance Utilization Review

TANF ..... Temporary Assistance for Needy Families

TB..... Tuberculosis

TCM ..... Targeted Case Management

TCP/IP ..... Transmission Control Protocol/Internet Protocol

TMSIS..... Transformed Medicaid Statistical Information System

TPL.....Third-party Liability

TTY/TTD .... Teletypewriter Device for the Deaf

UB-04..... Provider Claim Form (aka CMS-1450 Form)

UM..... Utilization Management

U.S. ..... United States

U.S.C. ..... United States Code

U.S.C.A ..... United States Code Annotated

VPN..... Virtual Private Network

X-ray..... Energetic High-Frequency Electromagnetic Radiation


Humana®