2026

South Carolina Humana Healthy Horizons and Humana Dual Integrated Provider Manual

Humana®

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

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Contents

Chapter 1: Introduction

Welcome

Welcome and thank you for becoming a participating provider with Humana Healthy Horizons® in South Carolina. Humana is a community-based health plan that serves members eligible for Medicaid and members dually eligible for both Medicaid and Medicare through the state of South Carolina.

This provider manual applies to providers serving Humana members enrolled in the Humana Healthy Horizons in South Carolina (Medicaid) plan; the Appendix of this provider manual applies to providers serving Humana members enrolled in the Humana Dual Integrated (HMO D-SNP), a Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP). A HIDE-SNP is a type of Medicare Advantage (MA) plan designed for individuals who are eligible for both Medicare and Medicaid benefits. This plan is referred to as HIDE-SNP throughout the rest of the manual.

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. 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.

Humana's 60+ years of managed care experience have allowed us to cultivate extensive expertise and resources, uniquely positioning us to form strong partnerships with South Carolina providers and effectively serve our members by making healthcare delivery simpler and reducing costs while improving health outcomes. We bring a history of innovative programs and collaborations to ensure your Humana-covered patients receive the highest quality of care, including community-based partnerships and services to help them successfully navigate complex healthcare systems. 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.

Purpose of this manual

The Humana Healthy Horizons in South Carolina and Humana Dual Integrated provider manual provides guidance for network providers on how to do business with Humana for the South Carolina market. It is an extension of the agreement between Humana and all provider types, including healthcare providers, 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.

For information on Humana Dual Integrated (HMO D-SNP) plan South Carolina (HIDE H1396-001), please refer to the **HIDE-SNP Appendix** of this provider manual. Additional information and images of the Humana Healthy Horizons member ID card can be found in Chapter 2: Member enrollment and eligibility. Additional information and images of the Humana Dual Integrated (HMO D-SNP) member ID card can be found in **HIDE-SNP Appendix Section 2: Member eligibility and enrollment**.

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.

Humana Healthy Horizons' managed care plan

Humana Healthy Horizons is a community-based health plan that serves Medicaid members throughout South Carolina.

As a managed care organization (MCO), Humana Healthy Horizons improves the health of our members by utilizing an integrated, contracted network of high-quality providers. Network PCPs deliver a variety of services directly, 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 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
- Improve member health
- Initiate a decrease in care 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 (SDOH), 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

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

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

Humana Healthy Horizons makes a difference

Humana Healthy Horizons 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 for members with frequent or higher than normal emergency department utilization
- A maternal and healthy baby program
- Discharge planning and transitional care support
- A disease management program for asthma and diabetes
- Disease management programs 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 Carolina 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 Healthy Horizons 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.

Compliance and ethics

At Humana Healthy Horizons, 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 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' 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

The 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 the Definitions section for more information about exclusion processes and lists
- Complete training required by Humana Healthy Horizons
- Conduct corresponding training of healthcare practitioners and administrative staff supporting any function for Humana Healthy Horizons
- Notify us of suspected violations or 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, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

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

Department	Phone number	Hours
Provider Services	866-432-0001	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Member 24-hour nurse advice line	877-837-6952	24 hours a day, 7 days a week
Prior authorization assistance for medical procedures and behavioral health	866-432-0001	Monday through Friday, 8 a.m. to 8 p.m., Eastern time

Department	Phone number	Hours
Prior authorization for pharmacy drugs	800-555-2546	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Pharmacy Help Desk	800-865-8715	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Medicaid case management	866-432-0001	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Availity Essentials™ customer service/tech support	800-282-4548	Monday through Friday, 8 a.m. to 8 p.m., Eastern time
Special Investigations Unit (SIU) Hotline	800-614-4126	24 hours a day, 7 days a week
Ethics Help Line	877-5-THE-KEY (584-3539)	24 hours a day, 7 days a week

Department	Mailing address
Provider 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 Grievances 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

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
- Referral and authorization submission and review

- Claim status lookup
- Claim submission
- Remittance advice access
- Claim appeal/dispute submission and management
- Medical record 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, Monday – Friday, 8 a.m. – 8 p.m., Eastern time or visit **https://www.availity.com/**.

Helpful website resources

Providers may obtain plan information from **Provider.Humana.com/HealthySC**. This includes details on the following:

- Health and wellness programs
- Provider.Humana.com/working-with-us/publications (includes the provider manual, Humana Physician News [quarterly newsletter] 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, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

Additional training opportunities through Relias

As a Humana Healthy Horizons® in South Carolina network healthcare provider, you can take advantage of Relias—a web-based continuing education library. Relias offers a variety of training modules and continuing education credits. Relias' training modules provide integrated information to support comprehensive care and address unique patient needs. Relias offers courses designed to help you succeed in the emerging value-based healthcare delivery system.

To learn more about the courses referenced or for additional/alternative options, refer to the module library by visiting the **Relias website** at **www.relias.com**, or sign in to your **Availity Essentials**™ account at **www.availity.com**, then:

- Select Humana under the Payer Spaces tab
- Select the Resources tab
- Select Relias Training

Chapter 2: 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 Healthy Horizons via an 834 file for members assigned to Humana Healthy Horizons. Eligibility begins on the first day of each calendar month for members joining Humana Healthy Horizons, with the exception of members otherwise identified by the state.

New member kits

Each new member receives a new member kit, a welcome letter and an ID card for each person in the family who has joined Humana Healthy Horizons. The new member kit is mailed separately from the ID card.

The new member kit contains:

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

New populations to managed care

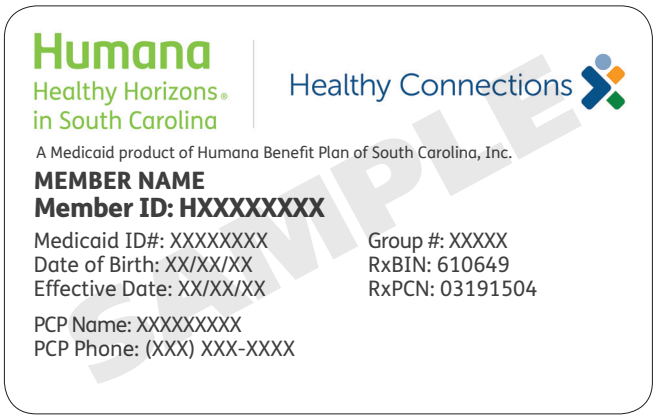
SCDHHS is carving in new populations into Medicaid managed care including duals from the Healthy Connections Prime demonstration, non-duals on the Community Long Term Care (CLTC), Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), and Mechanical Ventilator Dependent (VENT) waivers effective January 1, 2026. In addition, a Family Planning waiver will be coming later in 2026. SCDHHS seeks to improve health outcomes for full-benefit dual eligible (Medicaid and Medicare) beneficiaries by enabling their enrollment into MCO plans, effective January 1, 2026.

This manual will be updated regularly with any updates/changes to policies, processes, covered services, and value added benefits specific to these populations as they become available.

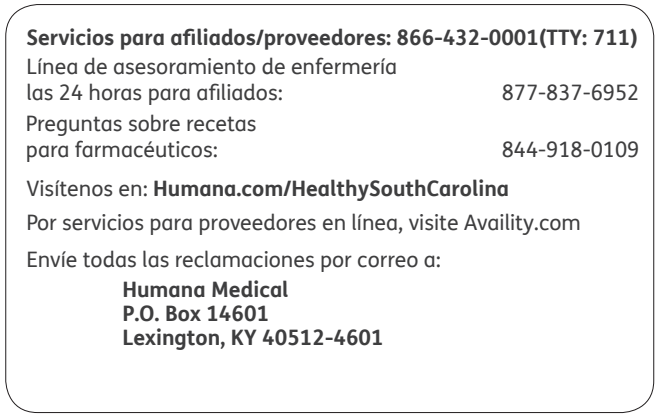
Member ID cards

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.

SC Medicaid English Card



SC Medicaid Spanish Card



Note: As of today this PDF meets State/Compliance guidelines and could be subject to change at any time. Notification will be communicated if Compliance guidelines change.

Front of Humana Healthy Horizons in South Carolina Member ID Card—English and Spanish

- Member name
- Humana member ID number—Humana UMID (Unique Member Identification No.) required for claims
- Medicaid ID number—required for all members
- Member's date of birth
- Effective date—indicates when member becomes eligible for benefits
- PCP name
- PCP phone number
- Group number
- RxBIN/RxPCN—needed for pharmacy benefits

Back of South Carolina Medicaid ID Card

- Member/Provider Services number—toll-free number for Q&A and TTY
- Member 24-hour nurse advice line
- Pharmacist Rx Inquiries number—toll-free number for Q&A
- Humana website
- Availity.com—for online provider services
- Claims address to submit paper claims

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 **Availity Essentials** at **www.availity.com**. You can check Humana Healthy Horizons member eligibility up to 24 months after the date of service. You can search by the Medicaid Management Information System (MMIS) number or the Humana Healthy Horizons member ID number and date of birth. You can submit multiple member IDs in a single request.

Automatic primary care provider assignment

A PCP is assigned automatically to all members. Humana Healthy Horizons' internal system can identify a member's previous PCPs within Humana Healthy Horizons' 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 Healthy Horizons PCP panel. Humana

Healthy Horizons' internal editing system also ensures the auto assigned PCP is age-appropriate for the member, that is, pediatric members will be assigned to pediatricians and adults assigned to a PCP who specializes in the treatment of adults. Members/providers may now fax requests to update their PCP, using the Primary Care Physician Change Request form found at **https://assets.humana.com/is/content/humana/SC_Primary_Care_Physician_Change_Request_Formpdf**.

Disenrollment

Humana Healthy Horizons, SCDHHS or the member can initiate disenrollment. A member may only be disenrolled from the Humana Healthy Horizons plan when authorized by SCDHHS. Members may disenroll from Humana Healthy Horizons for a number of reasons, including:

- Voluntary disenrollment within 90 days of initial enrollment with the MCO
- MCO not covering services requested by the member because of moral or religious objections
- Lack of access to MCO-covered services as determined by SCDHHS
- Moved out of the service area
- Poor quality of care
- Lack of access to experienced providers or specialists needed to meet member healthcare needs
  Humana Healthy Horizons can initiate member disenrollment for the following reasons:
- Member dies
- Member becomes an inmate of a public institution
- Member moves out of state or the contractor's service area
- Member elects hospice
- Member becomes Medicaid-eligible for institutionalization in a long-term care (LTC) facility/nursing home for more than 90 consecutive days
- Member elects a home- and community-based services (HCBS) waiver program
- Member becomes age 65 or older
- 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
- Member is placed in a care facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID)

Please notify the Humana Healthy Horizons Care Management department if any 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 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, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

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 CFR 438.102. The provider refers the member to another provider who is licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition. The provider must be actively enrolled with South Carolina Medicaid to provide Medicaid services to beneficiaries. The provider also must be in the Humana Healthy Horizons provider network.

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

- Medical providers: **SCProviderUpdates@humana.com**
- Behavioral health providers: **SCBHMedicaid@humana.com**

Chapter 3: 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 benefits and services, such as case management, disease management and nonemergency transportation coordination. Representatives are available by calling 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time. The Humana Healthy Horizons automated phone system may answer member calls on Saturdays, Sundays and some public holidays.

Member 24-hour nurse advice line

Members can call the nurse advice line at 877-837-6952, 24 hours a day, 7 days a week, 365 days a year. The toll-free number is listed on the member's ID card. Members have unlimited access to an experienced staff of registered nurses to discuss 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' behavioral health toll-free number at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

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, 7 days a week, year-round through the 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 Healthy Horizons works with those providers to authorize services and ensure continuity of care for the member.

The number to contact the CCRI Access Line is 833-364-2274, 24 hours a day, 7 days a week, 365 days a year. Members also may 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 support for parents

Humana Healthy Horizons' neonatal intensive care unit (NICU) care managers provide telephone-based services for the parents of eligible infants admitted to a NICU. Care managers in the Humana Healthy Horizons 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. Care managers work closely with healthcare providers 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

All providers of healthcare and related services are required to abide by federal and state regulations related to Sections 504 and 508 of the Rehabilitation Act, the Americans with Disabilities Act (ADA), 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.

For help with over-the-phone or sign language interpretation, please call 877-320-2233, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

Chapter 4: Covered services

Core benefits

It is the responsibility of Humana Healthy Horizons to notify SCDHHS as soon as it becomes 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 them 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 nonquantitative 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 hard-of-hearing children younger than 21 years of age whose hearing may or may not be improved with medication or surgical treatment
  - Includes services related to hearing aid use
  - Newborn hearing screenings rendered to newborns in an inpatient hospital setting
- BabyNet
  - Administered by SCDHHS, providing early intervention services for children from birth to age 3, including supports and resources to assist and enhance the learning and development of infants and toddlers with disabilities and special needs

- Behavioral health services
  - The full array 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
- Communicable disease services
- Disease management
- Durable medical equipment (DME)
- Early and Periodic Screening, Diagnostic and Treatment (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 (Department of Health and Humana Services [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 surgery if it clearly states the patient was informed prior to 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 requires a hysterectomy, and prior acknowledgment is 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
  - Covered through the Vaccines for Children (VFC) Program
- Immunizations (vaccines) for adults ages 19 years and older
  - Covered as recommended by the Advisory Committee on Immunization Practices (ACIP)
- Independent laboratory and X-ray services
- Inpatient hospital services
- Institutional LTC facilities/nursing facilities (NFs)
- Maternity services
- Outpatient services

- Physician services
- Pharmacy/prescription drugs
- Psychiatric Collaborative Care Model (CoCM) Services
- 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 (DHHS 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 or 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 use
- 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

Emergency transportation

Members who have a medical emergency and require emergency transportation services should call 911.

Member costs

Covered medical services are provided at no cost to the member. Humana Healthy Horizons has waived all copays.

Excluded services

The services detailed below 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 South Carolina state Medicaid plan. Payment for these services remain Medicaid fee-for-service. Humana Healthy Horizons is responsible for the continuity of care for all Humana Healthy Horizons members by ensuring appropriate service referrals are made for the members 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
- Early intervention (EI) services (that are not provided as part of the BabyNet program)

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

Value-added benefits

Humana Healthy Horizons offers members value-added 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 value-added benefits are in excess of the amount, duration and scope of those services listed above. In instances where a value-added benefit is also 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 value-added benefits:

Value-added benefit	Details and limitations
Baby and me meals	Up to 2 precooked, home-delivered meals per day for 10 weeks are available for pregnant women who are high risk. Care manager approval is required.
Breast pumps	Pregnant and postpartum female members can receive 1 non- hospital-grade breast pump every 2 years.

Value-added benefit	Details and limitations
Convertible car seat and portable crib	Pregnant members are contacted once we are notified the mom is expecting. During the call or through a call to Customer Care, pregnant moms can confirm if a car seat and crib are needed prior to delivery. Pregnant members who do not need the crib or car seat prior to delivery are asked to enroll and actively participate in our HumanaBeginnings® care management program, 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 or car seat). Members who need the crib and car seat prior to delivery will receive the items and also will be contacted for a postpartum assessment along with a follow-up call. This applies per infant, per birth.
Healthy food produce box	Members living with or at risk of living with chronic conditions, Humana Healthy Horizons offers up to 4 produce boxes per year containing nutritious food that meets medical dietary guidelines, and educational materials that include recipes tailored to our member's condition. Members must have at least 1 of the following qualifying chronic conditions: • Congestive heart failure • Chronic obstructive pulmonary disease • Chronic kidney disease • End-stage renal disease • Cancer • Human immunodeficiency virus • Serious mental illness • Diabetes Type I • Diabetes Type II

Value-added benefit	Details and limitations
General Education Diploma (GED) testing	GED test preparation assistance for members 16 and older is available, 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. This also includes a test pass guarantee to provide members multiple attempts at passing the test. Members ages 16 to 18 need a Verification of Withdrawal from South Carolina Schools Form completed by the principal or attendance supervisor of the last school attended. The GED test may be taken at age 19 or older without the Verification of Withdrawal from South Carolina Schools Form.
Home-based asthma interventions	Members can receive up to $200 allowance per year for allergen free bedding, carpet cleaning and/or air purifier. Member must be asthmatic.
Housing assistance	Members 18 and older can receive up to $500 per member per year to assist with the following housing expenses: • Apartment rent or mortgage payment (late payment notice required) • Utility payment for electric, water or gas (late payment notice required) • Trailer park and lot rent if this is a permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority Plan approval is required: • 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.

Value-added benefit	Details and limitations
Housing support for SMI members	Members diagnosed with Serious Mental Illness and eligible for Intensive Case Management who are homeless, at imminent risk of becoming homeless, or transitioning from a behavioral health inpatient or residential facility without stable housing may be eligible for housing assistance up to $5,000. This once per lifetime assistance can cover rent/mortgage, security deposits, and utility deposits, household furnishings/supplies, and moving expenses. Benefits will be tailored to meet functional needs of each member. Members must meet the following criteria: • Diagnosed with Serious Mental Illness • Eligible for Intensive Case Management • 18 and older • Homeless (per U.S. Department of Housing and Urban Development (HUD) definition) or at imminent risk of becoming homeless (i.e., becoming evicted or losing current housing) • Must be able to continue paying for his/her expenses upon award of this one-time benefit • Voluntarily consents to housing support allowance
Newborn circumcision	Circumcision for all newborn male members from 29 days old through 12 months.
Non-medical transportation	Members 18 and older receive 15 round trips (or 30 one-way trips), up to 30 miles, of nonmedical transportation per year to locations that address health-related social needs (HRSN)). Examples include social support groups; wellness classes; Women, Infants, and Children (WIC), and Supplemental Nutrition Assistance Program (SNAP) appointments; and food banks. This benefit also includes transportation to locations providing social benefits and community integration for members such as community and neighborhood centers, parks, recreation areas and churches.

Value-added benefit	Details and limitations
Over-the-counter (OTC) pharmacy allowance	Up to $65 per quarter allowance enables members to purchase products that support common occurring conditions, including: • Pain relievers • Diaper rash cream • Cough and cold relief medicine • First aid equipment that does not require prescriptions Unused amounts do not roll over to the next quarter.
Post-discharge meals	Up to 14 pre-cooked, home-delivered meals that can be stored in the refrigerator following an inpatient or residential facility admission up to 4 times per year.
Produce box for maternal care	Pregnant members that are between their second trimester to 60 days postpartum that are deemed food insecure can receive up to 4 boxes of in-season, nutritious, fresh food annually with Care Manager approval.
Self-monitoring device: blood pressure monitoring kit	Members can receive a Digital Blood Pressure Kit, which includes a cuff and monitor, every 3 years • Member is 21 and older • Prior authorization is required for members under 21 years old • The age limit and/or prior authorization does not apply to members who are pregnant or within 3 months postpartum
Smartphone services	With a smartphone, you have easy access to health- related information and can stay connected to your care team and health plan. Any member who qualifies for the Federal Lifeline program will be eligible to receive a free smartphone with monthly talk minutes, text, and data.
Sports physical	1 sports physical per year is available for members 6 to 18 years of age.

Value-added benefit	Details and limitations
Tobacco and vaping cessation coaching	Tobacco & Vaping Cessation Coaching is focused on helping members aged 12 and older with stopping their usage of nicotine products. The program is designed as a monthly engagement for a total of 8 coaching calls, but the member has 12 months to complete the program if needed. The program also offers support for both over the counter (OTC) and prescription nicotine replacement therapy (NRT) for members aged 18 and older.
Vision services	Members 21 and older can receive an annual eye exam and an annual allowance of up to $150 to cover glasses frames and/or contact lenses.
Weight management coaching	Weight Management Coaching helps members who are 12 and older achieve or maintain a healthy weight. Members can complete 6 sessions with a Wellness Coach; approximately 1 call per month for a period of 6 months.
Youth academic support	Empowering students to reach their full academic potential, this benefit offers personalized tutoring services for members between ages 5 - 18. With up to 20 hours of tutoring available over a 10-week period each year, students receive targeted assistance to enhance their learning experience and excel in their studies.
Youth development and recreation	Members 18 and younger can receive reimbursement of up to $250 annually for participation in activities such as: • YMCA • Boys and Girls Club • Swim lessons • Computer coding classes • Music lessons

Go365 for Humana Healthy Horizons

Go365 for Humana Healthy Horizons® is a well-being and rewards program available to our Humana Healthy Horizons members. For each eligible Go365 activity completed, members can earn rewards and redeem the rewards for gift cards in the Go365 in-app mall.

Most rewards are earned by Humana Healthy Horizons' 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 March 15 of the following year. This allows members time to redeem their rewards.

Members have 90 calendar days from one plan year to another to redeem their rewards, assuming they remain continuously enrolled.

Unless otherwise stated, all rewards are offered to Medicaid-only members. Members can qualify to earn rewards by completing 1 or more of the activities in the chart below.

Healthy activity	Reward
Annual wellness visit	Annual $25 reward for members ages 3 and older for completing an annual wellness visit.
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 test.
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.
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	Once per lifetime $20 reward for downloading the Go365 for Humana Healthy Horizons app and updating communication preferences.
Flu vaccine	Annual $20 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 annual reward for members who receive 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 behavioral health visit	$25 annual reward for members who receive follow-up care within 30 days after a hospital discharge for a behavioral health diagnosis.
Health risk assessment (HRA) completion	Annual $20 reward for completing the HRA.

Healthy activity	Reward
Human papillomavirus (HPV) vaccine	One-time $20 reward for members ages 9–13 who receive two doses of the HPV vaccine between the ages of 9-13.
Postpartum visit	$25 reward for females who complete one postpartum visit within seven to 84 days after delivery, once per pregnancy.
Prenatal visit	$10 reward for each prenatal visit completed by a pregnant member, up to 10 per pregnancy, $100 annual max
Tobacco & Vaping Cessation Coaching	Members 12 and older can earn rewards for working 1:1 with a Wellness Coach to quit tobacco: • $25 reward for completing two calls within 45 days of enrollment in the program • $25 reward for completing the program More information is available in the Go365 for Humana Healthy Horizons app. To get started, members can call 800-955-0782 and press 1 for Tobacco & Vaping Cessation Coaching.
Weight Management Coaching	Members 12 and older who work with a Wellness Coach to manage their weight can earn: • $15 reward for completing enrollment • $15 reward for completing the program More information is available in the Go365 for Humana Healthy Horizons app. To get started, members can call 800-955-0782 and press 2 for Weight Management Coaching.
Well-child visit (0–15 months)	Members 0-15 months can earn $10 for completing a routine well-child visit, up to 6 visits, $60 annually.
Well-child visit (16–30 months)	Members 16-30 months can earn $10 for completing a routine well-child visit, up to 2 visits, $20 annually

How to redeem rewards

To earn and redeem rewards, members must:

- Download the Go365 for Humana app from iTunes/Apple Shop or Google Play on a mobile device.
- Create an account to access and engage in the program. (If the member has a MyHumana account, they can use the same login information to access Go365, after they download the app.)

- If they are 18 and older, register to create a Go365 account. They must have their Medicaid Member ID.
- If they are under the age of 18, they must have a parent or guardian register on their behalf to participate and engage with the program. The person completing the registration process on behalf of a minor must have the minor's Medicaid Member ID.

If members have questions about the Go365 program, they can call the number on the back of their Humana ID card.

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 nontransferable to other managed care plans or other programs. Rewards are nontransferable and have no cash value. E-gift cards may not be used for tobacco, alcohol, firearms, lottery tickets and other items that do not support a healthy lifestyle.

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 or 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.

Chapter 5: Behavioral health

Behavioral health and substance-use services under Humana Healthy Horizons

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 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 healthcare providers for most outpatient behavioral health services without prior authorization. Providers should refer to the Prior Authorization List (PAL) at **https://provider.humana.com/coverage-claims/prior-authorizations/prior-authorization-lists** to obtain a list of services requiring prior authorization.

Specialized behavioral health services constitute several services, including:

- Inpatient hospitalization for behavioral health and substance use 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:
  - Individual, family, group and multifamily group psychotherapy

  - Psychological evaluation and testing
  - Psychological evaluation and treatment
  - Individual therapy with medical evaluation, management and case consultation
  - Assessment and screening
  - Medication management
  - Medication administration
  - 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 serious and persistent mental illness [SPMI])
  - Peer support services (PSS)
  - School-based mental health services
  - Assertive Community Treatment (ACT) services

Providers, members or other responsible parties can contact Humana Healthy Horizons at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time to verify available benefits and seek guidance in obtaining services for behavioral health and substance use issues.

Our network focuses on improving member health through evidence-based practices. Our goal is 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 or phone, or via Availity Essentials.

- Online: through **www.availity.com**
- Phone: 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time
  Email: **CorporateMedicaidCIT@humana.com**
- Fax: 833-441-0950

Prior authorization request forms are available on our provider website at **Provider.Humana.com/medicaid/south-carolina-medicaid/prior-authorization** or by contacting the Behavioral Health department and requesting the necessary forms be faxed to you. If a form is required for a particular service, it can be uploaded and submitted with the prior authorization request within Availity Essentials. Authorization requests should include a diagnostic assessment, treatment plan and any

additional clinical information that supports the request. For questions regarding prior authorization requirements or to obtain authorization, call 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

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 healthcare providers. These services include intensive family treatment services, adolescent treatment facilities, inpatient psychiatric hospitals, private residential treatment facility services and waiver programs.

Rehabilitative behavioral health services

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

RBHS include 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 SMI who require a higher level of community care and have not been well supported in lower level-of-care options
- Behavioral modification (B-MOD)—Used to provide the member with redirection and modeling of appropriate behaviors to enhance function in the home and/or community
- Psychosocial rehabilitation services (PRS)—Intended as a skill-building service for members, not a form of psychotherapy or counseling
- Family support (FS) services—Utilized to enable the family/caregiver to engage with the treatment team for a member and/or improve their ability to care for the member
- Community integration services (CIS)—Targeted treatment service for adults ages 18 years and older with SPMI
- Therapeutic child care (TCC)—Targeted treatment services for children younger than age 6 who experienced trauma, neglect or abuse and are in need of early intervention

Additional services included in the RBHS benefit include individual psychotherapy, group psychotherapy, family psychotherapy, behavioral health screenings and diagnosis assessment, medication management, peer support services and substance use disorder treatment.

RBHS provided by licensed or certified clinicians must follow supervision requirements as required by South Carolina state law. Please see the RBHS provider manual at **www.scdhhs.gov/providers/manuals/rehabilitative-behavioral-health-services-rbhs-manual** for supervision requirements. Case supervision and consultation do not negate training requirements. Supervision frequency 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 bills Humana Healthy Horizons
- Hire their own counselors and bill Humana Healthy Horizons directly
- Contract with a private provider who bills Humana Healthy Horizons directly
- Use a combination of these delivery methods to meet the needs of the children in their district

Autism spectrum disorder

Humana Healthy Horizons also provides autism spectrum disorder (ASD) coverage for members younger than 21 years. This benefit includes ASD services rendered by board-certified behavior analysts (BCBAs), board-certified assistant behavior analysts (BCaBAs) and registered behavioral technicians (RBTs), as well as by licensed independent practitioners (LIPs) who are approved by the South Carolina Department of Disabilities and Special Needs (SCDDSN) to provide evidence-based treatment (an applied behavior analysis [ABA] alternative therapy modality). Humana Healthy Horizons adheres to guidelines as outlined in the SCDHHS Autism Spectrum Disorder (ASD) Services Provider Manual at **https://www.scdhhs.gov/sites/dhhs/files/documents/Autism%20Spectrum%20Disorder%20(ASD)%20Services%20Provider%20Manual%209.1.2025.pdf**.

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 at **https://provider.scdhhs.gov/internet/pdf/manuals/Psychiatric/Manual.pdf**. Prior authorization is required for all acute inpatient admissions. Acute inpatient services provided in free-standing psychiatric facilities include behavioral health and 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 with a mental health practitioner for adults and children 6 years and older within 7 calendar days of hospitalization for a mental health disorder
  - An outpatient visit with a mental health practitioner for adults and children 13 years and older within 7 calendar days of hospitalization for substance use disorder

A SCDHHS Certificate 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 Provider Manual. 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.

* HEDIS® is a registered trademark of the NCQA.

Residential substance use treatment

Humana Healthy Horizons covers residential substance use treatment. Residential substance use 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 facility (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 Provider Manual. Prior authorization along with a completed certificate of need (CON) form is required.

Opioid treatment programs (OTPs)

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 (UM) team works with providers and the member to transition to an in-network provider. Prior authorization is not required for opioid treatment program (OTP) services. However, members must meet certain requirements to qualify for and seek treatment from an in-network provider. Consult the **www.scdhhs.gov/providers/manuals/clinic-services-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 7 days of the discharge date. Behavioral healthcare providers are expected to contact patients within 24 hours of a missed appointment to reschedule.

Chapter 6: Early and Periodic Screening, Diagnostic and Treatment

Early and Periodic Screening, Diagnostic and Treatment (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 special services needed to address health issues as soon as identified or suspected. EPSDT benefits are available at no cost to members.

Early and Periodic Screening, Diagnostic and Treatment 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 EPSDT preventive exams include the following components:

- 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 integrated into well-child visits at 1, 2, 4 and 6 months

Early and Periodic Screening, Diagnostic and Treatment 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 Medicaid for South Carolina residents. Note the following special considerations:

- 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 of whether those services are covered by Medicaid for South Carolina residents.
- 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.

Early and Periodic Screening, Diagnostic and Treatment 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 **www.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 **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 **www.scdhhs.gov/sites/dhhs/files/documents/filez1/documents/Pediatric%20Medical%20Periodicity%20(April%202018).pdf**.

The dental benefit is a component of SCDHHS Healthy Connections through the DentaQuest vendor. DentaQuest offers coverage based on the SCDHHS fee schedule and coverage policies. More information can be found in the SCDHHS Dental Services Provider Manual at **www.scdhhs.gov/providers/manuals/dental-services-manual**.

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 ACIP, the Bright Futures/ 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 **www.aap.org**.

The South Carolina Department of Public Health offers immunization programs for eligible adults and children. Additional information on the VFC Program, the South Carolina State Vaccine Program and the Adult Vaccine Program can be found at **www.dph.sc.gov/public/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 (CPT®) code for the vaccine product that is administered; however, only the administration code is reimbursable.

Chapter 7: 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. Humana Healthy Horizons offers provider educational resources tailored specifically for pharmacists and medication management. For comprehensive details about pharmacy services in South Carolina, please refer to the dedicated **pharmacy manual** at **https://provider.humana.com/pharmacy-resources/manuals-forms**.

Utilization management

Humana's comprehensive drug list (CDL) identifies covered drugs and associated drug UM requirements, such as prior authorization, quantity limits, etc.

- Prior authorization: The medication must be reviewed using a criteria-based approval process prior to coverage decision.
- Drug safety limits: Facilitate the appropriate, approved label use of various classes of medications, for example, drug- drug interaction, opioid limits and therapeutic duplication.

72-hour emergency supply

For claims where a pharmacist is unable to fill a medication that is denied at the point of sale for error codes requiring prior authorization, Humana Pharmacy Solutions will allow the pharmacist to fill an emergency 72-hour supply based on the pharmacist's clinical judgement. This includes unbreakable package items as well (e.g., albuterol inhalers or insulin).

- When a claim is denied at the point of sale due to requiring 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, which is provided in the denial message.
- Once the pharmacist submits the claim using SCC 65, the system will override the prior authorization denial and allow a 3-day supply to be dispensed.
- The claim 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 noncovered drugs, that is, those excluded from Medicaid benefit drugs and/or categories:

- Agents used for anorexia and 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
- Agents prescribed for gender dysphoria

Comprehensive drug list updates

SCDHHS may add or remove drugs on the CDL throughout the year. We also may change our UM requirements for covered drugs. Examples include:

- Elect to require or not require prior authorization
- Elect to change the quantity limits
- Update, add guidance or implement new clinical guidelines for a drug from the Food and Drug Administration (FDA)
- Make decisions on whether to add a new to market generic or brand

All negative changes are posted to our website at least 30 days prior to implementation. Please visit our website at **Provider.Humana.com/medicaid/south-carolina-medicaid/documents-resources** for updates.

Please review the current CDL prior to writing a prescription to determine if a drug is covered. The CDL is updated regularly; to view the current CDL, go to **Humana drug lists for providers**. To view current medical and pharmacy coverage policies, please visit **Humana.com/coveragepolicies**.

Medications administered in the provider setting

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

Obtain forms at **Provider.Humana.com/SCPriorAuthorizations**

- Submit a request by fax to 888-447-3430.
- View preauthorization and notification lists at **Provider.Humana.com/PAL**.

Coverage determinations and exceptions

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

Obtain forms at **Provider.Humana.com/SCPriorAuthorizations**

Submit requests electronically by visiting **www.covermymeds.health/prior -authorization-forms/humana**.

- Submit requests by fax to 877-486-2621.
- Call Humana Clinical Pharmacy Review (HCPR) at 800-555-CLIN (2546), Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

Coverage determination decisions are reviewed based on medical necessity; decisions are communicated within 24 hours after the request is received for urgent request and 72 hours for standard request.

Medication appeals

If we deny the member's coverage determination, you can ask for a review of our decision by making an appeal on behalf of the member. You may request medication appeals, via the following methods:

- Submit requests by fax to 877-556-7005.
- Call Humana Clinical Pharmacy Review (HCPR) at 800-451-4651, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

Electronic prescribing

Through our participation in the Surescripts network, our pharmacy benefit manager (PBM) eligibility, CDL 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 CDL, 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 signing in to **Humana.com**.

Members have access to Humana Healthy Horizons' mail-order pharmacy, CenterWell Pharmacy®, which sends medications directly to their home, and other available mail-order options that can be found on **Humana.com/medicaid/south-carolina/coverage/pharmacy**. 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 (TTY: 711), Monday through Friday, 8 a.m. to 11 p.m., and 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., and Saturday, 8 a.m. to 6 p.m., Eastern time

Over-the-counter health and wellness

Humana Health Horizons members have an expanded pharmacy benefit, which provides a $65 quarterly allowance to spend on over-the-counter (OTC) health and wellness items.

Unused OTC allowances do not roll over to the next quarter. These OTC products will be sent via FedEx, UPS or the U.S. Postal Service within 10 to 14 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 **South Carolina Medicaid Coverage: Pharmacy - Humana**.

If you have questions about this mail-order service, please call CenterWell Pharmacy at 855-211-8370 (TTY: 711), Monday through Friday, 8 a.m. to 11 p.m., and 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 claims activity for signs of misuse or abuse in accordance with state and federal laws. Quarterly reports are generated by the Division of Program Integrity, which reviews all Medicaid members claims for a six-month period. The report is reviewed for 20 different weighted criteria as established by the Division of Program Integrity. Based on criteria met, a score is assigned that is used in identifying members for the Statewide Pharmacy Lock-In Program (SPLIP). In addition, members may be reviewed for the SPLIP based on data mining of pharmacy and medical claims data to identify recipients who have an excess of medication fills. Members who obtained two or more controlled substance medications from two or more prescribers and utilized two or more pharmacies within 180 days and have a documented diagnosis of narcotic poisoning or drug abuse within the last 365 days will be reviewed for the lock-in program. Prescribers within the same practice are counted as a single prescriber. Pharmacies with multiple locations that share real-time data are counted as one pharmacy. 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 2 years, during which members 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 MCOs, the member will continue to be in the SPLIP program continuously, regardless of transfers between MCOs or Medicaid eligibility. Following the member's 2-year enrollment, the member's future claims are monitored. If the member meets the established criteria, the member will be re-enrolled in the SPLIP.

Excluded from enrollment in the lock-in program are:

- Members in hospice, or no longer Medicaid eligible
- Members younger than 14 years old
- Members currently in a lock–in program
- Members with sickle cell disease (International Classification of Diseases, 10th Revision [ICD-10] codes D57.00 through D57.1, D57.20 through D57.219 and D57.4 through D57.819)
- Members enrolled in both Medicaid and Medicare

Chapter 8: Utilization management

UM 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 UM 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 Healthy Horizons care management team are made, if needed. Humana Healthy Horizons completes an assessment of satisfaction with the UM process on an annual basis, identifying areas for improvement.

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
- Milliman Care Guidelines (MCG) and 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 providers related to medically appropriate care and treatment.

Humana Healthy Horizons 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 Healthy Horizons 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 provider from an NCQA-certified independent review organization. The Humana Healthy Horizons medical director utilizes the plan's criteria, the director's personal medical expertise and external resources to determine if the request for services should be approved or denied. All adverse benefit determinations are communicated in writing to the member and requesting healthcare provider. This communication provides the reason(s) for denial and how to initiate the appeal process. At any time, the requesting healthcare provider may contact Humana Healthy Horizons to request a copy of the criteria used to make the final determination. Additionally, the Humana Healthy Horizons medical directors are available to discuss medical necessity determinations with the requesting healthcare provider.

Healthcare providers may contact the UM centralized intake team to request a peer-to-peer discussion within 5 calendar days of the adverse benefit determination. To request a peer-to-peer discussion, please call 866-432-0001 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern time, and select "Authorization and Provider" when prompted.

Clinical criteria and clinical rationale used in making adverse UM determinations are available upon request by contacting our UM department:

Medical health inquiries: Call 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time or email **SCMCDUM@humana.com**.

Behavioral health inquiries: Call 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time or email **SCMCDUM_BH@humana.com**.

Providers can obtain Medicaid prior authorization requirements and clinical criteria by visiting **Provider.Humana.com/coverage-claims/prior-authorizations/prior-authorization-lists**.

Written requests for criteria used to make a determination can be sent to:

Humana Correspondence

P.O. Box 14601

Lexington, KY 40512-4601

Submit by fax: 800-266-3022

Submit by phone: 800-523-0023

Staff access

Providers may contact the UM staff with any UM questions.

Medical health inquiries: Call 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time or email **SCMCDUM@humana.com**.

Behavioral health inquiries: Call 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time 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 available to answer questions about the UM process.

In the best interest of our members and to promote positive healthcare outcomes, Humana Healthy Horizons 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 Healthy Horizons are available to discuss individual cases with attending providers on request.

If you would like to request a peer-to-peer discussion on a medical necessity adverse determination with a Humana Healthy Horizon physician reviewer, please contact our clinical intake team at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time within 5 calendar days of the determination.

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 or 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.

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 the 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 7 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 provides 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 time frames 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 provider that are not specifically defined in the current CPT or Healthcare Common Procedure Coding System (HCPCS) coding book(s). These codes require the following:

- Prior authorization
- Report with a description of the nature, extent and need for the procedure
- A comparative CPT code 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, Monday through Friday, 8 a.m. to 8 p.m., Eastern time or you can access the PAL at **Provider.humana.com/coverage-claims/prior-authorizations/prior-authorization-lists**.

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 BabyNet Prior Authorization Form*
- Universal Newborn Prior Authorization Form*

* These forms can be found on the South Carolina Healthy Connections Medicaid site under Reference Tools: **: www.scdhhs.gov/providers/managed-care/managed-care-organizations-mco/managed-care-resources**.

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

- Visit Availity Essentials at **www.availity.com**.
- Access various prior authorization forms online at **Provider.Humana.com/medicaid/south-carolina-medicaid/prior-authorization**.
- Email completed forms to **CorporateMedicaidCIT@humana.com**.
- Fax completed prior authorization forms to 833-441-0950.

Call 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time 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
- Provider name, National Provider Identifier (NPI) and Tax Identification Number (TIN) for ordering/servicing providers and facilities
- Provider's contact information to include phone and fax to aid in outreach of additional clinical if necessary
- 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 calendar days from the date of service, 180 calendar days from the inpatient discharge date or 180 calendar days from 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, Monday through Friday, 8 a.m. to 8 p.m., Eastern time and following the appropriate menu prompts. You also may fax the request to 833-441-0950. Clinical information supporting the service must accompany the request.

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 noncontracted 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 calendar 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 cost 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 will cover the cost of continued access to the prenatal care provider (whether contract or noncontract provider) for 90 calendar days postpartum, 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 postpartum period.

If you have additional questions regarding Humana Healthy Horizons' continuity of care process and authorizations for new members, please call 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

Chapter 9: 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 claim processing and payment delivery.

Please note: Failure to include ICD-10 codes on electronic or paper claims will result in claim denial.

Claim submissions

Claims, including corrected claims, must be submitted within one year of 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 to file a written dispute.

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

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

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

- Patient (member) name
- Patient address
- Insured's ID: Be sure to provide the complete Humana Healthy Horizons member ID for the patient.
- Patient's date of birth: 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 Centers for Medicare & Medicaid Services (CMS) location codes.
- ICD-10, Clinical Modification (ICD-10-CM) diagnosis code(s)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant CPT or HCPCS code(s) and modifier(s), when applicable

- Units, where applicable (anesthesia claims require number of minutes)
- Date(s) 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.
- NPI: Please refer to the Location of Provider NPI, TIN and member ID section of this manual.
- TIN or provider Social Security number: Every provider practice (e.g., legal business entity) has a different TIN.
- Billing and rendering taxonomy codes that match the SCDHHS Master Provider List (MPL)
- Billing and rendering addresses that match the SCDHHS MPL
- Signature of provider or supplier: The provider's complete name should be included. If we already have the provider's signature on file, indicate "signature on file" and enter in the date field the date the claim was signed.

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 adjudication date.

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

Electronic funds transfer/electronic remittance advice

Electronic claim payment offers you several advantages over traditional paper 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 (EOR).
- 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.

Electronic funds transfer/electronic remittance advice enrollment through Humana Healthy Horizons

Get paid faster and reduce administrative paperwork with EFT and ERA. Healthcare providers can use Humana's ERA/EFT enrollment tool on Availity Essentials to enroll.

- Sign in to Availity Essentials at **www.availity.com** (registration required).
- From the Payer Spaces menu, select Humana.

- From the Applications tab, select the ERA/EFT enrollment app. (If you don't see the app, contact your Availity Essentials 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 (ACH) Association 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 also is 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 HIPAA. Humana Healthy Horizons utilizes Availity Essentials 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

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
- Referral and authorization submission and review
- Claim status lookup
- Claim submission
- Remittance advice access
- Claim appeal/dispute submission and management
- Medical record submission and management
- Overpayment management
- ERA/EFT enrollment and management

To learn more, call 800-282-4548, Monday – Friday, 8 a.m. – 8 p.m., Eastern time or visit **www.availity.com**.

For information regarding electronic claim submission, contact your local provider agreement representative or visit **Provider.Humana.com** and choose "Claims Resources" and then "Electronic Claims & Encounter Submissions" or visit **www.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. Below are some commonly used clearinghouses. 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 claim clearinghouses and their phone numbers:

Availity	800-282-4548, Monday through Friday, 8 a.m. to 8 p.m., Eastern time
TriZetto	800-556-2231, Monday through Friday, 8 a.m. to 7 p.m., Eastern time
Optum	800-792-5256, Monday through Friday, 9 a.m. to 7 p.m., Eastern Time
SSI Group	800-820-4774, Monday through Friday, 8 a.m. to 8 p.m., Eastern time

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 for implementing ICD-10-CM codes in 2015. The new standard is the HIPAA 5010 format.

The following transactions are covered under the ANSI ASC X12N (005010A1) requirements:

- 837P/837I Claims encounters
- 835 Electronic remittance advice

- 276/277 Claims status inquiry
- 270/271 Eligibility
- 278 Prior authorization requests
- 834 Enrollment
- National Council for Prescription Drug Programs (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:

- HCPCS, which includes:
  - CPT codes, available from the American Medical Association (AMA) at **http://AMA-assn.org/practice-management/cpt**
  - HCPCS Level II codes, available from CMS at **www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update**
- National Drug Codes (NDCs), available from the U.S. Food and Drug Administration (FDA) at **www.fda.gov/drugs/drug-approvals-and-databases/national-drug-code-directory**
- ICD-10-CM, available from the Centers for Disease Control and Prevention at **www.cdc.gov/nchs/icd/icd-10-cm/files.html?CDC_AAref_Val=https://www.cdc.gov/nchs/icd/Comprehensive- Listing-of-ICD-10-CM-Files.htm**
- ICD-10, Procedure Coding System (ICD-10-PCS), available from CMS at **www.cms.gov/medicare/coding/icd10**

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

Please note: 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.

NPI, TIN and taxonomy

Your NPI and TIN 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.

SCDHHS requires all NPIs, billing and rendering addresses, and taxonomy codes be present on its (MPL). Claims submitted without these numbers, or including 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, TIN or taxonomy numbers on the electronic claim form you submit.

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

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; the ZZ qualifier in box 24I for rendering provider taxonomy

The billing provider TIN must be submitted as the secondary provider identifier using an REF segment, which is either the employer identification number (EIN) for organizations 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 in box 81

On all electronic claims, the Humana Healthy Horizons member ID number should be in the following location:

- 2010BA Loop = subscriber name
- NM109 = member ID

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 CMS and the National Uniform Claim Committee (NUCC).

Detailed instructions for completing forms are available at the following websites:

- CMS-1500 form Instructions: **https://nucc.org**
- UB-04 form Instructions: **www.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 character recognition/intelligent character recognition (OCR/ ICR) systems to capture claim information to increase efficiency and to improve accuracy and turnaround time. We cannot accept handwritten claims or superbills.

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 National Drug Code 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 3 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 superbills, 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 printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- A TIN or provider Social Security number 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 nonemergency 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 2 years from the date of service or within 6 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

- The COB requires a copy of the appropriate remittance statement from the primary carrier payment:
  - Electronic claims—the primary carrier's payment information
  - Paper claims—EOB from the primary carrier
- Medicare COB claims—The appropriate remittance statement must be received within 2 years of the date of service or within 6 months of Medicare adjudication.
- Non-Medicare primary payer—The appropriate remittance statement must be received within 2 years of the date of service or within 6 months of the date of the primary payer's Explanation of Benefits (EOB) or remittance advice.
- If a claim is denied for COB information needed, the provider must submit the appropriate remittance statement from the primary payer within the COB claim timely filing period.

Newborn claims

All claims for newborns must be submitted using the newborn's Humana Healthy Horizons ID and Medicaid ID. Newborn infants are deemed eligible for Medicaid and automatically enrolled by the birthing hospital with Humana Healthy Horizons if claims are sent within 3 months of birth.

Coverage for the mother continues for 12 months after the baby's birth. The infant is covered up to age 1. Do not submit newborn claims using the mother's ID or the claims will be denied. Claims for newborns must include birth weight.

Home health services and electronic visit verification 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, member's care plan and in accordance with the established schedule, including the amount, frequency, duration and scope of each service, and that services are provided in a timely manner. Providers must work with Humana Healthy Horizons to identify and immediately address service gaps, including late and missed appointments.

Other claim requirements

Abortion, sterilization and hysterectomy procedure and initial hospice claim submissions must have consent forms attached. The forms can be found in the "Forms" tab of the hospital services and physician services provider manuals **(www.scdhhs.gov/providers)**.

Claims indicating 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.

Claim compliance standards

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

- Humana Healthy Horizons pays 90% of all clean claims submitted from providers, including Indian healthcare providers, within 30 calendar days of the date of receipt.
- Humana Healthy Horizons 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 acknowledgment and payment of all submitted claims for services:

- Issue payment for a clean, paper claim within 30 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, 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 30 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, 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 maintains a system for determining the date claims are received. Electronic claim acknowledgment is sent electronically to either the provider or the provider's designated vendor for the exchange of electronic healthcare transactions. The acknowledgment identifies 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 healthcare transactions within 30 business days of the submission of the claim whether submitted electronically or on 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 2 years from the date of service or discharge, or within 6 months from the date of Medicare payment, whichever is later.

Claim status

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

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

- Reason for payment or denial
- Procedure/diagnostic

Claim payments by Humana Healthy Horizons to providers are accompanied by an itemized accounting of the individual claims in the payment that includes the member's name, the date of service, the procedure code, service units, the reimbursement amount and identification of Humana Healthy Horizons.

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 Healthy Horizons processes accurate and complete provider claims in accordance with Humana Healthy Horizons' normal claims processing procedures, including, but not limited to, claim processing edits (**Humana.com/Edits**), claim payment policies (**Humana.com/ClaimPaymentPolicies**), and applicable state and/or federal laws, rules and regulations. See the coverage and claims section of **Provider.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 Healthy Horizons' claims processing procedures is dependent upon 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:
  - 2 or more surgeries performed the same day
  - 2 or more endoscopic procedures performed the same day
  - 2 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 claim includes more than 1 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 member
- 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
- AMA's CPT and associated AMA publications and services
- CMS' HCPCS and associated CMS publications and services
- 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
- FDA guidance
- Medical and surgical specialty societies and associations
- Industry-standard utilization management criteria and/or care guidelines
- Humana Healthy Horizons 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 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 **Provider.Humana.com**.

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

Providers are required to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. Claims indicating provider-preventable conditions are not to be paid.

Humana Healthy Horizons provides notification of upcoming code editing changes. We publish new code editing rules and our rationale 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 5 business days of receipt of a SCDHHS Division of Program Integrity notification. A prepayment review is then conducted in a manner consistent with the request of the Division of Program Integrity notification. This prepayment review is conducted until Humana Healthy Horizons has been notified by the Division of Program Integrity to cease the prepayment review.

Humana Healthy Horizons will also, at its discretion, place providers suspected of fraud, waste or 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 there is a credible allegation of fraud in accordance with 42 CFR 455.23.

Coordination of Benefits

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 require Medicaid programs to be the payer of last resort.

While we try to maintain accurate information at all times, we rely on numerous sources for updated information, and some updates may not always be reflected 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 in **Availity Essentials** by:

- Patient ID and date of birth
- Medicaid ID 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.

Coordination of Benefits 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 the member's 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, Monday through Friday, 8 a.m. to 8 p.m., Eastern time 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 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 5 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 claim(s) 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 claim(s) 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 MCO to validate that 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.

Chapter 10: Care management and care coordination

Humana Healthy Horizons care managers are available to promote a holistic approach to addressing a member's physical and behavioral healthcare needs as well as SDOH issues. Humana Healthy Horizons offers chronic condition management programs for physical health, behavioral health and substance use, as well as care management programs based on the member's level of need. Humana Healthy Horizons 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 SDOH needs, including food and housing resources.

We welcome referrals from providers. Call Humana Healthy Horizons at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time or send an email to: Medical: **SCMCDCareManagement@humana.com**

Behavioral health: **SCMCDCareManagement_BH@humana.com**

HumanaBeginnings: **SCMCDHumanaBeginnings@humana.com**

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

The care management programs discussed in the following section are:

- Chronic condition management program
- HumanaBeginnings maternal child program
- Complex care management for complex members
- Intensive care management (ICM)

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

Chronic condition management program

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

- Improve member understanding and assist with self-management of member's 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, healthcare providers, 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 maternal child program

Humana's HumanaBeginnings program is designed to have proactive engagement with all expectant mothers and their newborns. The HumanaBeginnings program provides perinatal, neonatal, prenatal and postnatal 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, members and community agencies. The expertise offered by staff includes a focus on patient education and support and involves direct telephone contact with members and providers, with a primary objective of achieving positive birth outcomes and encouraging early and ongoing prenatal and postpartum care.

We encourage our prenatal care providers to notify care management support services at

866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time when a pregnant member is identified or if case management is needed. Providers also can complete the Medicaid Notification of Pregnancy Form at **3121_LC12062SC0821_SC_Notification of Pregnancy** and send it to us via fax at 833-441-0948 or email at **SCMCDHumanaBeginnings@humana.com**.

Complex care management program

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. These members typically have multiple comorbidities or have a single serious diagnosis such as HIV or cancer. Within the complex care management program, care coordinators focus on providing education, coordination of care and ongoing support.

Intensive care management program

Members eligible for intensive case management are identified as high risk and require intensive, highly focused attention to support their clinical care needs and to address SDOH. Care coordinators in the ICM program serve as liaison to and coordinate care with relevant providers, natural supports and peer support specialists as needed. Care coordinators proactively assist members with gaining access to HCBS, physical health services, transportation and other identified resources, along with transition planning when needed. A care coordinator's primary function in the program involves meeting members in their least restrictive setting to engage and support improved health outcomes.

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 multidisciplinary 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 **www.availity.com** and available on request by contacting our care management team at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

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-covered patient with chronic conditions that you believe would benefit from this program, you may have your patient reach us directly, submit a referral on your patient's behalf by calling Member/Provider Services at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time or email us at:

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.

Chapter 11: Provider disputes

A provider dispute may be filed online via Availity Essentials or via telephone, electronic mail, surface mail or in person within 30 calendar days of receipt of notice of adverse action.

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 pertinent facts from all parties; and applying Humana Healthy Horizons' written policies and procedures. The provider dispute resolution team resolves the issue within the time period identified in the table, titled "Claims dispute FAQ topic."

Providers can submit disputes for:

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

Disputes regarding denial of payment or reduction of payment can be filed for:

- One member/claim
- One member and multiple claims
- A 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 **www.availity.com**; use the Claim Status tool to locate the claim and select 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, sign into Availity Essentials, select "Help & Training" and then select "Get Trained."
- Verbally, via telephone, by calling 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time
- Via email at **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 Healthy Horizons staff member (e.g., care coordinator, nurse)
  - Via a Humana Healthy Horizons office

The information to be documented or submitted should include:

- Person calling, submitting or speaking with name, phone number and/or email address
- Provider/facility TIN
- Provider/facility name
- Member ID and name
- Claims number(s)
- Authorization/referral number(s)
- Details of dispute/issues

Claims dispute FAQ topic	Response
What is the time frame for a provider to submit a claims dispute?	Within 30 calendar days of the date of the final determination of the primary payer
What communication and resolution time frame can be expected?	• Providers will receive a resolution letter within 30 calendar days of receipt. • If additional information is required to render a decision on the dispute, a status letter may be sent on the 30th day requesting a 15-day extension, not to exceed 45 calendar days from the date of receipt.
What if there are additional questions or concerns?	Our Customer Care representatives are available at 866-432-0001 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

Chapter 12: Member grievances and appeals

This section outlines the member's Medicaid appeal rights and Medicaid grievance process. For provider disputes regarding an issue you are having or for 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.

A grievance may include 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 the member's 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 **SC_MBR_AOR_Formpdf**.

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

We mail a written resolution letter to the member or the member's representative within 90 calendar days of the date we receive the grievance.

Grievances can be submitted orally, in writing or in person. To submit a grievance orally, the member or the member's representative may call Member Services at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time. Alternatively, a grievance may be submitted in writing at the following address:

Grievances and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax: 800-949-2961

Member appeal process

An appeal is a request to review an adverse benefit determination issued by Humana Healthy Horizons. The member, the member's 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 in person, orally via Member Services or in writing within 60 calendar days of the date on the notice of adverse benefit determination.

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 **SC_MBR_AOR_Formpdf**.

Providers can request reconsideration regarding post-service payment issues; see the **Provider disputes** section of this manual for more details.

It is important that we 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 the appeal. For an expedited appeal, as outlined in the next section, we must receive all supporting information within 72 hours of 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 the previous decision and are not a subordinate of any individual involved in the previous decision. For appeals regarding a denial based on lack of medical necessity, a grievance due to a denial of an expedited resolution for an appeal or any grievance or appeal involving clinical issues, the reviewers will be healthcare professionals with the appropriate clinical expertise in treating the member's condition.

We provide our members reasonable assistance in completing forms and other steps to submit an appeal or grievance, 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 5 business days of the date we receive the request. For standard preservice 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 select 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 **Provider.Humana.com/working-with-us/web-based-training training**.

Phone: To submit an appeal orally, you may call Member Services at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

- In person
- Mail or fax:

  Grievances and Appeals Department

  P.O. Box 14546

  Lexington, KY 40512-4546

  Fax: 800-949-2961

Member expedited appeal 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, the member's authorized representative or by the member's provider, with the member's written consent. 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 the member's behalf.

You may submit the request in person, orally via Member Services or in writing within 60 calendar days of the date on the notice of adverse benefit determination 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 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 we send a letter within two calendar days explaining the decision to deny the expedited processing 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 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 the member's representative may:

- Review all of 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 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 time frame.

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 of the date on 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 of the date the member or the member's representative filed the appeal with Humana Healthy Horizons, not including any days to file the request for a State 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 3 business days. If the request to expedite the hearing is denied, the hearing will follow the standard 90-day time frame.

Continuation of benefits while appeal or State Fair Hearing is pending

While the State Fair Hearing or appeal is pending, we continue paying for the member's benefits if all of the following conditions are met:

- The member or the member's 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 a 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.
- The member requests the benefits to continue (providers are unable to request that the member's benefits continue).

If the member requests a continuation or reinstatement of 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 Fearing.
- 10 calendar days have passed after the date the notice of adverse benefit determination was mailed.
- 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 Healthy Horizons approves the services within 72 hours of 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 State Fair 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).

Chapter 13: Provider rights and responsibilities

Provider rights

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

- To be able to advise or advocate on behalf of a Humana Healthy Horizons member, when acting within the lawful scope of practice, for the following:
  - The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
  - Any information the member needs to decide among all relevant treatment options
  - The risks, benefits and consequences of treatment or nontreatment
  - The member's right to participate in decisions regarding the member's healthcare, including the right to refuse treatment and to express preferences about future treatment decisions
- To receive information on the grievance, appeal and fair hearing procedures
  - To have access to Humana Healthy Horizons' policies and procedures covering the authorization of services
- To be notified of any decision by Humana Healthy Horizons to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested
- To challenge, on behalf of Humana Healthy Horizons members, the denial of coverage of, or payment for, medical assistance
- To be free from discrimination from Humana Healthy Horizons' provider selection policies and procedures for serving high-risk populations or specializing in conditions that require costly treatment
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who acts within the scope of the provider's 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 Healthy Horizons provider agreement. You must:

- Have a professional degree and a current, unrestricted license to practice medicine in the state in which the 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 Healthy Horizons, on request, assists SCDHHS to periodically revalidate South Carolina Medicaid provider status, and Humana Healthy Horizons 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 Healthy Horizons' quality assurance, quality improvement, accreditation, risk management, utilization review, UM, clinical trial and other administrative policies and procedures established and revised by Humana Healthy Horizons.
- Be credentialed by Humana Healthy Horizons and meet all credentialing and recredentialing 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 Section 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 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 Healthy Horizons.
- Assume responsibility for a member 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 Healthy Horizons concerning the member's care or the member is discharged.
- Inform Humana Healthy Horizons 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 Healthy Horizons 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 that would affect your participation status with Humana Healthy Horizons.

- Not discriminate against members as a result of their participation as members or 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 ACA, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the ADA 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 provider services to members 24 hours a day, 7 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 members with problems outside your normal scope of practice for consultation and/ or care to appropriate specialists that are 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 providers 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 or other fees that are the member's responsibility under the terms of the member's benefit plan.
- Provide services in a culturally competent manner, (e.g., removing language barriers, arranging and paying for interpretation services for limited English proficient [LEP] and hard of hearing /visually impaired members) 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., **https://minorityhealth.hhs.gov/** and **https://thinkculturalhealth.hhs.gov/**).
- Provide access to healthcare benefits for all members in a manner consistent with recognized standards of healthcare; 42 CFR 422.504(a)(3)(iii) and SCDHHS requirements and covered in this manual.

- Provide or arrange for continued treatment to all members, including 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.
- Safeguard information about Medicaid managed care members according to applicable state and federal laws and regulations, including 42 CFR 431, Subpart F, and HIPAA, 45 CFR Parts 160 and 164.
- Provide an electronic automated means, at the request of Humana Healthy Horizons 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 medical records, for all payer responsibilities, including case management, UM, claim review and audit, and claim 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 Healthy Horizons, the member or the requesting party, unless otherwise agreed.
- Provide copies of, access to and the opportunity for Humana Healthy Horizons 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. The purpose of this access is to help guarantee compliance with all financial, operational, quality assurance and 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. A related organization or entity is defined as having:
  - Influence, ownership or control
  - Either a financial relationship or a relationship for rendering services to the primary care office
- Assume full responsibility to the extent of the law and to the extent applicable to the provider, when supervising/ sponsoring, whether through a protocol, collaborative or some other type of agreement; physician assistants; advanced practice registered nurses; nurse practitioners; 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 Healthy Horizons 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 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 ACA, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the ADA and the Rehabilitation Act of 1973.
- Perform services under the agreement that are consistent and in compliance with Humana Healthy Horizons' contractual obligations under its South Carolina Medicaid contract(s). You agree to cooperate with and assist Humana Healthy Horizons in its efforts to comply with its South Carolina Medicaid contract(s) and/or rules and regulations and to assist Humana Healthy Horizons in complying with corrective action plans necessary for Humana Healthy Horizons to comply with such rules and regulations.
- Submit complete member referral information when applicable and in a timely manner to Humana Healthy Horizons 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 Healthy Horizons 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 Healthy Horizons' 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 Healthy Horizons 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 guide, 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 healthcare providers who provide services to Humana Healthy Horizons members. You (and/or your organization) agree to provide a copy of said agreement(s) to Humana Healthy Horizons on request (financial information is not requested). The subcontract or delegation includes all stated requirements of the contract with us, including 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 Healthy Horizons or the member to enforce the terms of this provision.
- Understand and agree that provider performance data can be used by Humana Healthy Horizons.

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 Healthy Horizons 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 achieve year-over-year compliance.
- Visiting **Provider.Humana.com/ProviderCompliance** to learn how 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 Healthy Horizons, promptly remove any excluded party from supporting us and notify us in a timely manner of the exclusion and action(s) taken.
  - See the **Definitions section** for more information about exclusion lists.
- Complete separate, required training sessions 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 Healthy Horizons identifies noncompliance, fraud or abuse.
- Notify us in a timely manner of suspected violations, misconduct, or FWA 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 provider 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 Healthy Horizons. We will only assign members to a nurse practitioner or physician assistant when members notify us of the selection. 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
- Initiating referrals for specialty care
- Maintaining the continuity of patient care 24 hours a day, 7 days a week
- Obtaining hospital admitting privileges or a formal referral agreement with a PCP 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 and 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
- Reporting instances of tuberculosis and other communicable diseases to the 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
- Developing 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 CFR Parts 160 and 164 and all state statutes
  - For more information, 45 CFR 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 provider who has admitting privileges at an in-network hospital
- Working with Humana Healthy Horizons case managers to develop plans of care for members receiving care management services
- Participating with the Humana Healthy Horizons care management team, as applicable and medically necessary
- Conducting screens for common behavioral issues including depression, anxiety, trauma/adverse childhood experiences, and substance use; early detection; identification of developmental disorders/delays; social-emotional health and 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, 7 days a week
- Making referrals for specialty care and other medically necessary services, both in network 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 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 Healthy Horizons 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

At the first medical appointment, PCPs have the responsibility to discuss advance medical directives with adult members 18 or older who are of sound mind.

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)).

Primary care provider request for member transfer

PCPs may request a member's disenrollment from the PCP's 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' policy regarding involuntary dismissal of a member from a PCP's practice includes the following:

- Incompatibility of the PCP/patient relationship where the member does not respond to recommended patterns of treatment or behavior. Examples include:
  - Repeated failure to modify behavior as requested
  - Repeated noncompliance with medication schedules
  - Repeated violation of no-show office policies
    - At least 3 PCP documentation 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
- Inability to meet the medical needs of the member
- 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 Member Services at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time to choose another PCP
  - Emailing a copy of the certified dismissal letter that was sent to the member to Humana Healthy Horizons at **SCMedicaid@humana.com** and include the following:
    - Provider name
    - Provider TIN
    - Provider address and phone
    - Member name
    - Member ID
    - Member address and phone
    - Member date of birth

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 PCPs and medical/behavioral health specialists are required to ensure adequate accessibility to healthcare 24 hours a day, 7 days a week, 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:

- Within 48 hours of a request for primary care or behavioral healthcare
- Within 48 hours of referral or notification from PCP for specialty care Appointments for routine and wellness visits should be provided:
- Within 4 to 6 weeks of member's request for PCP appointment
- Within 4 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:

- Immediately on presentation at a PCP service delivery site
- 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 hours a day, 7 days a week, by Medicaid-enrolled providers who will accept Medicaid reimbursement. This coverage should consist of an answering service, call forwarding availability, provider call coverage or other customary means approved by the agency. The chosen method of 24 hours a day,7 days a week 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 must arrange 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. Additional access requirements include:

- In-office waiting times for any scheduled medical service visit cannot exceed 45 minutes.
- Walk-in members with nonurgent 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 members if the provider serves only Medicaid managed care members.
- Female members must be provided with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive healthcare services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

- A second opinion must be provided from a qualified healthcare professional within the network or arranged 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 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 PHI, 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 PHI for treatment, payment and healthcare operations.

Member consent to share health information

Consent is the member's written permission to share the member's 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 treatment:

- SHI is defined by the state (e.g., HIV/AIDS, mental health, sexually transmitted diseases).
- Substance use disorder 42 CFR Part 2 at **www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2?toc=1** pertains to federal requirements that apply to all states.

While all member data is protected under the HIPAA Privacy Rules, 42 CFR 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 **www.availity.com** and any health information exchanges. Please explain to your patients that if they do not consent to let Humana Healthy Horizons 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 4 regional locations throughout the state.

Required training

We expect adherence to all training programs identified as compliance-based by the contract and Humana Healthy Horizons. 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.

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 SCDHHS and/or our compliance program:

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

* 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.

† Your organization is responsible for developing or adopting another organization's training on the separate topics of general compliance and combatting FWA. While Humana Healthy Horizons 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.

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 FWA

All new providers also will receive Humana Healthy Horizons' Medicaid provider orientation training.

Online training is available via Availity Essentials. Directions for the topics listed above can be accessed by anyone 24 hours a day, 7 days a week at **Provider.Humana.com/ProviderCompliance**. For additional information, visit **Provider.Humana.com/HealthySC**.

Key contract provisions

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

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 Healthy Horizons 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 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 recorded message used after hours, members must have the ability to contact their PCP or a backup provider to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your backup provider and only recommends emergency room (ER) use for after hours.
- Submitting claims and corrected claims within 1 year of the date of service or discharge
- Filing written disputes within 30 calendar days of the receipt of a Notice of an Adverse Action
- Keeping all demographic and practice information up to date

By agreement, Humana Healthy Horizons 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 paying 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 Healthy Horizons 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 Healthy Horizons 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 also are required to have an 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 Healthy Horizons verifies current South Carolina Medicaid provider status using data provided by SCDHHS. Humana Healthy Horizons 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 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 the 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 the office

Notification of changes should be sent via email to:

- Medical providers at **SCPproviderUpdates@humana.com**
- Behavioral health providers at **SCBHMedicaid@humana.com**

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

Americans with Disabilities Act

All Humana Healthy Horizons 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 Healthy Horizons 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 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

Delivering high-quality care means recognizing and respecting the diverse cultural, linguistic, and social backgrounds of the individuals we serve. Providers are expected to offer services in a culturally and linguistically appropriate manner, ensuring that no patient faces barriers due to language, cultural beliefs, or social circumstances.

Humana Healthy Horizons is committed to building a provider network that reflects the diversity of our members and promotes health equity. This includes compliance with all applicable federal and state laws and regulations, such as:

- Title VI of the Civil Rights Act of 1964
- The Age Discrimination Act of 1975

- The Americans with Disabilities Act (ADA)
- The Rehabilitation Act of 1973

We recognize that race, ethnicity, language, and socioeconomic status significantly influence healthcare experiences and outcomes. Cultural misunderstandings, language barriers, and differing health beliefs can contribute to disparities in care. Providers play a vital role in bridging these gaps through culturally competent communication and care delivery.

A 2023 workshop hosted by the National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality (AHRQ) emphasized that a healthcare workforce reflective of the cultural and linguistic diversity of the communities it serves is essential to advancing health equity. The workshop highlighted the importance of understanding cultural foodways, communication styles, and social norms in improving care outcomes for underrepresented populations.

Practical Tips for Providers

To support culturally competent care, providers should:

- **Offer language assistance services** at no cost to patients with limited English proficiency, including qualified interpreters and translated materials.
- **Collect and use race, ethnicity and language data** to identify disparities and tailor interventions.
- **Participate in cultural competency training** to enhance awareness of implicit bias, communication styles and culturally influenced health behaviors.
- **Respect cultural health beliefs and practices**, and incorporate them into care plans when appropriate.
- **Use plain language and confirm understanding** through teach-back methods, especially during cross-cultural interactions.

Humana Healthy Horizons supports providers with:

- Access to **language services**
- **Training modules** on cultural awareness and health equity
- **Data tools** to identify and address gaps in care
- **Educational materials** from trusted health organizations

Together, we can ensure that every member receives respectful, responsive, and equitable care—regardless of their background.

A copy of Humana Healthy Horizons' Cultural Competency Plan is provided at no charge to the provider. To request a paper copy, please contact Humana Healthy Horizons Provider Services at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

Humana Healthy Horizons also offers directions to training materials on this topic at **Provider.Humana.com/ProviderCompliance**.

Chapter 14: 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:

Member rights

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 healthcare
  - 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.
- 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.
- Receive all services that the plan must provide and to get them in a timely manner
- Get timely access to care without any communication or physical access barriers
- Have reasonable opportunity to choose the provider that delivers care whenever possible and appropriate
- Choose a PCP and change to another PCP in Humana Healthy Horizons' network
  - The member will receive written notification confirming the PCP change.
- Change providers
- Request a practitioner that has their same race, ethnicity and language, if there is a practitioner available in the network
- 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.
- Get timely access and referrals to medically indicated specialty care
- Be protected from liability for payment

- 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.
- Ask questions and get complete information about their health and treatment options in a way that they can understand, including specialty care
- Have a candid discussion of any appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage
- Take an active part in decisions about their healthcare unless it is not in their best interest
- Say yes or no to treatment or therapy
  - If they say no, the provider or Humana Healthy Horizons must talk to them about what could happen. A note must be placed in the medical record.
- Be treated with respect, dignity, privacy, confidentiality and nondiscrimination
- Have access to appropriate services and not be discriminated against based on health status, religion, age, gender or other bias
- Be sure that others cannot hear or see them when getting medical care
- 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 CFR 438.206 through 438.210
- Get help with their medical records in accordance with applicable federal and state laws
- Be sure their medical records are kept private
- Ask for and receive a copy of their medical records and be able to ask for their health records to be changed or corrected if needed
  - Records are retained for 5 years or longer as required by federal law.
- Be able to say yes or no to having information given out unless Humana Healthy Horizons must provide it by law
- 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
- Get help, free of charge, from Humana Healthy Horizons and our providers if they do not speak English or need help to understand information
- Get help with sign language if hearing impaired
- Be told if a healthcare provider is a student and be able to refuse that provider's care

- Be told if care is experimental and be able to refuse to be part of that care
- Know that Humana Healthy Horizons 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.
- Be able to go to a woman's health provider in our network for covered woman's health services
- Voice complaints or appeals about Humana Healthy Horizons or the care it provides
- 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 SCDHHS.
- To make advance directives, such as a living will
- Contact the Office for 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

  P.O. Box 1520

  Columbia, S.C. 29202-520

  Phone: 800-311-7220
- Receive information about Humana Healthy Horizons, our services, our practitioners and providers, and member rights and responsibilities
- Make recommendations to our member rights and responsibility policy
- To go out of network when approved and at no cost if Humana Healthy Horizons is unable to provide a necessary and covered service in our network
  - We will do this for as long as we cannot provide the service in network. The member has a right to go out of network when approved.
- Be free to carry out their rights and know that Humana Healthy Horizons and/or our providers do not hold this against them

Any Indian enrolled with Humana Healthy Horizons eligible to receive services from a participating Indian Health Service, Tribally Operated Facility/Program or Urban Indian Clinic (I/T/U) provider or an I/T/U PCP shall be allowed to receive services from that provider if the provider is part of the Humana Healthy Horizons network.

Member responsibilities

Members have the responsibility to:

- 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 respect

Tell us if they have problems with any healthcare staff by calling Member Services at 866-432-0001 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern time

- Keep their appointments and call 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
- Know their rights
- Follow Humana Healthy Horizons 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 as possible about their health issues
- Take part in developing and reaching goals that are agreed upon with their healthcare provider
- Let Humana Healthy Horizons know if they suspect healthcare fraud or abuse
- Let Humana Healthy Horizons know if they are unhappy with us or one of our providers
- Use only approved providers
- Report any suspected FWA using the information provided in this manual
- Keep scheduled doctor visits and be on time
  - If it's necessary to cancel, the member should 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.
- Contact their PCP after going to an urgent care center, having a medical emergency or getting medical care outside of Humana Healthy Horizons' service area

- Let Humana Healthy Horizons and 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
- Notify us immediately of any workers' compensation claim, a pending personal injury or medical malpractice lawsuit, or if they have been involved in an auto accident
- Inform Humana Healthy Horizons of the loss or theft of ID cards

Humana Healthy Horizons advises members of any changes to our member rights and responsibilities on our website at **Provider.Humana.com/HealthySC**.

Chapter 15: Quality improvement

Overview

Humana Healthy Horizons' quality improvement 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 are implemented in response to findings. Using a continuous quality improvement methodology, the quality improvement program works to:

- Monitor systemwide 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 quality improvement program activities include monitoring clinical indicators or outcomes, quality studies, HEDIS measures and/or medical record audits. Chaired by the health plan's chief medical officer, the Quality Assurance Committee is delegated by Humana Healthy Horizons' board of directors to monitor and evaluate the results of program initiatives and implement corrective action when the results are less than desired or when areas needing improvement are identified.

The goals of the quality improvement program are to:

- Develop clinical strategies and provide clinical programs that look at the whole person, while integrating behavioral and physical healthcare
- Identify and resolve issues related to member access and availability to healthcare services
- Identify, track, review and analyze adverse or critical incidents to identify, 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 Healthy Horizons 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 healthcare 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 providers 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' quality improvement program, which includes providing member records for assessing quality of care. In addition, the 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 PHI to health plans without member authorization for treatment, payment and healthcare operations activities. Healthcare operations include the health plan conducting quality assessment and improvement activities and population-based activities related 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 quality improvement program on an annual basis. Information regarding the quality improvement program is available on request and includes a description of the quality improvement program and a report assessing the progress in meeting goals.

An annual report is published that reviews completed and continuing quality improvement activities and addresses the quality of clinical care and service, trends measures to assess performance in quality of clinical care and service, identifies any corrective actions implemented or corrective actions that are recommended or in progress, and identifies any modifications to the quality improvement 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, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

Provider 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 providers to earn financial incentives based on quality and clinical outcomes. The programs are designed based on the provider's panel size and engagement. The programs are reviewed and reimbursed annually. Annual payments are made in the following quarter to allow for reporting/data collection. To learn more about these programs, please contact your provider engagement professional or call Provider Services at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

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 centers and institutes. They help providers make decisions regarding appropriate healthcare for specific clinical circumstances. Humana Healthy Horizons 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 Healthy Horizons 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 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 are available on our website at **provider.humana.com** under the patient care section.

Healthcare Effectiveness Data and Information Set

Healthcare Effectiveness Data and Information Set (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, for example, PDF documents of completed attestation forms and medical records. Nonstandard data also can be accepted electronically via a proprietary Electronic Attestation Form or Practitioner Assessment Form. 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, electronic medical record [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 file transfer protocol (FTP) transmission. Humana Healthy Horizons 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 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 (name and date of birth) information on each page
- Personal/biographical data, including date of birth, age, sex, gender, marital status, race and 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), identification of language spoken and written, and if applicable, need for communication assistance, and guardianship information, Medicaid identification number, consent forms (signed and dated as applicable), including consent for treatment
- Services provided through Humana Healthy Horizons, full medical records including date of service and data entry, service site and name of service provider
  - All clinical entries in the health record, including progress or treatment notes must be complete, legible and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service.
- Provider identification by name
- A complete immunization record
- Allergies or no known allergies 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, and drugs administered/dispensed
- For pediatric patients (younger than 21 years of age), past medical history, including 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 noted
- Documentation of immunization status and a current immunization record to appear in the patient chart
- Preventative screenings offered or referred, (e.g., EPSDT; dental exams; eye exams; breast, cervical and colon cancer screenings), along with the results of those referrals

- Diagnostic testing
  - The record should show documentation of labs, x-rays, imaging or other studies ordered. Results should be filed in the medical record and initialed by the PCP, signifying review. Tests with abnormal results should have explicit notation regarding a follow-up plan. Notification should be made to the patient of all results (positive or negative).
- Identification and history of or exposure to smoking/vaping nicotine and tobacco, alcohol use or substance use for all members 12 years of age and older
- Interval history including after-hours/hospital follow-up
  - If a member utilized these services, documentation should include: emergency department and/or after-hours encounters; hospital reports including admission and discharge summaries; follow-up visits and results/outcomes. Follow-up visits are provided secondary to reports of emergency room (ER) care.
- Advance medical directives (for members 18 and older)
  - Documentation should include evidence of discussion about the advance directive and a copy of the signed document (if completed).
- All written denials of service and the reason for the denials
- Signature and title or initials of the provider rendering the services
  - 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.

All medical records must adhere to the following:

- The record must be legible to someone other than the writer. Any record judged illegible by one reviewer will be evaluated by another reviewer.
- All clinical entries in the health record, including progress or treatment notes, must be complete, legible and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service.
- Health records must be signed and dated at the time of service. If this is not done, the rendering provider must attest to the date and time as appropriate to the media. In cases where a provider is attesting to the date and time, information including the rendering provider and date and time of the service must be verifiable.
- Different providers may add information to the same progress or treatment note, if necessary. When this occurs, each provider must sign their individual entries, verifying the work they performed.
- The health records media must have the capability to identify changes to an original entry such as addendums, corrections, deletions and patient amendments. When making changes, the date, time, author making the change and reason for the change must be included.
- Undocumented, undated and unsigned record amendments, corrections or addendums will not be accepted.

- Any changes to the original entry must contain enough information to determine the date when the service was performed or ordered.
- A progress or treatment note must support the diagnosis of the condition, medical necessity and detail the extent of the service performed. This is used to ensure the service is billed with the correct and appropriate level of procedure code, as defined in the CPT or the HCPCS nomenclatures and descriptors, or as indicated in SCDHHS' policy.
- The record must contain sufficient information to identify the patient, date of service and services provided.

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 use status
- Diagnosis or medical impression
- Vital signs: height, weight, body mass index (BMI) percentile, blood pressure and temperature
- 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, throat, teeth, neck, heart, lungs and neurological and musculoskeletal systems
- Subjective findings:
  - History/description of symptoms/current problem list containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health status and 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, (e.g., EPSDT), addressed from previous visits
- Plan of treatment, including:
  - Medication history and 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 CFR 456.172 [for mental hospitals] or [for hospitals])
- Initial and subsequent continued stay review dates (described under 42 CFR 456.233 and 42 CFR 465.234 [for mental hospitals] and 42 CFR 456.128 and 42 CFR 456.133 [for hospitals])
- Reasons and plan for continued stay, if applicable
- Other supporting material appropriate to include
- For nonmental hospitals only:
  - Date of operating room reservation
  - Justification of emergency admission, if applicable

The member's medical record is the property of the provider that generates the record. In addition, Humana Healthy Horizons 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 5 years unless federal requirements mandate a longer retention period (e.g., immunization and tuberculosis records are required to be kept for a person's lifetime). According to **www.scdhhs.gov/communications/administrative-and-billing-provider-manual-updates#%3A~%3Atext%3DMB** for Healthy Connections Medicaid purposes:

- All fiscal and health records shall be retained for a minimum period of 4 years after the last payment was made for services rendered.
- Hospitals and nursing homes are required to retain such records for 6 years after the last payment was made for services rendered.

If any litigation, claim, audit or other action involving the records has been initiated prior to the expiration of the applicable retention period, the records shall be retained until completion of the action and resolution of all issues that arise from it or until the end of the applicable retention period, whichever is later.

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 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 upon request. Information from the health records review may be used in the recredentialing 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 Section 438.204. The review includes an examination of quality outcomes and the timeliness of, and access to, the services covered under the contract.

Patient safety to include quality of care and service

Humana Healthy Horizons supports implementation of a complete range of patient safety activities. These activities include medical record legibility and documentation standards, communication, 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 and postpartum care for pregnant women
- Well-baby care
- Immunizations for children, adolescents and adults
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density and sexually transmitted diseases, and Pap tests 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 performance 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 that 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 ensure all HIPAA guidelines are enforced.
- Performance measures—Data collected on patient outcomes as defined by HEDIS or otherwise defined by the agency
- Surveys—Consumer Assessment of Healthcare Providers and Systems (CAHPS®), 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
- Clinical data platform analytics—Review of provider practice performance by fostering collaboration among payers, providers and patients

Web resources

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

Fraud, waste 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 and 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 provider or the provider's office staff:

- Is aware of any 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 the member's 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 the member's enrollment form that materially affects the member's eligibility

Providers may provide the above information via an anonymous phone call to Humana Healthy Horizons' fraud hotline at 800-614-4126, 24 hours, 7 days a week, 365 days a year. All information will be kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Humana Healthy Horizons ensures no retaliation against callers as Humana

Healthy Horizons has a zero-tolerance policy for retaliation or retribution against any person who reports suspected misconduct. Providers also may contact Humana Healthy Horizons at 800-4HUMANA (448-6262), Monday through Friday, 7 a.m. to 8 p.m., Eastern time and SCDHHS at 888-364-3224, Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time. In addition, providers may use the following contacts:

Phone:

SIU Hotline: 800-614-4126 (24 hours a day, 7 days a week access)

Ethics Help Line: 877-5-THE-KEY (584-3539)

(24 hours a day, 7 days a week access)

Email:

SIUReferrals@humana.com or **ethics@humana.com**

Web:

https://secure.ethicspoint.com/domain/media/en/gui/60750/index.html

Chapter 16: Credentialing and recredentialing

Humana Healthy Horizons conducts credentialing and recredentialing activities using the guidelines established by SCDHHS, CMS and NCQA. Humana credentials and recredentials all licensed independent practitioners with whom it contracts and who fall within its scope of authority and action, including physicians, facilities and nonphysicians. Through credentialing, Humana Healthy Horizons verifies the qualifications and performance of physicians and other healthcare practitioners. A senior clinical staff person is responsible for oversight of the credentialing and recredentialing program. Providers will be informed of the credentialing committee's decision within 30 business days of the committee meeting. On SCDHHS selection and implementation of a credentials verification organization (CVO), Humana Healthy Horizons accepts the credentialing and recredentialing decisions of the CVO's credentials committee for our Humana Healthy Horizons in South Carolina Healthy 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 after 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 recredentialing

All providers appearing in the provider directory are subject to credentialing and recredentialing. Practitioners included within the scope of credentialing for South Carolina Medicaid include the following:

Medical health practitioners:

- Medical and osteopathic providers
- Oral surgeons
- Chiropractors
- Podiatrists
- Dentists

- Optometrists
- Allied health providers, including advanced practice registered nurses, clinical nurse specialists, 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 PCP, or those that appear in the provider directory

Behavioral health practitioners:

- Psychiatrists and other behavioral health physicians
- Addiction 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 Healthy Horizons is a participating organization with CAQH. You can confirm we have access to your credentialing application by completing the following steps:

1. Sign in to the CAQH website at **https://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 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
- Current DEA certificate
  - All buprenorphine prescribers must have an "X" DEA number.
- Explanation of any lapse in work history of 6 months or greater
- 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

- A copy of the practitioner's Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if the practitioner holds a foreign medical degree

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

Practitioner credentialing and recredentialing access

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

- Signed and dated credentialing application, including supporting documents
- Active and unrestricted license in the practicing state issued by the appropriate licensing board and enrolled with SCDHHS as a qualified Medicaid provider
- Previous 5-year work history
  - Current 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 medical doctors and doctors of osteopathy, 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 Excluded Parties List System [EPLS])
- Active and valid South Carolina Medicaid ID
- 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, are required to provide evidence that a formal relationship exists with a Humana Healthy Horizons participating supervising physician through collaborative agreement. Such collaborative agreement must include established admitting arrangements to a Humana Healthy Horizons-participating facility.

Organizational credentialing and recredentialing

Organizational providers, defined as hospitals or other healthcare facilities, are assessed during credentialing and recredentialing 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 use services in an inpatient, residential or ambulatory setting
- Dialysis centers
- Physical and occupational therapy and speech language pathology (PT/OT/SLP) facilities
- Rehabilitation hospitals (including outpatient locations)
- Diabetes education
- Portable X-ray suppliers
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- 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
  - HHS-OIG
  - GSA (formerly EPLS)
- The organization has been reviewed and approved by an accrediting body.
- A completed application with signature and date that includes a copy of the facility's state license, as applicable, and a current copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, as applicable, must be provided.

- 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.
- FQHCs supply evidence of Notice of Grant Award under Sections 319, 330 or 340 of the Public Health Service Act. FQHC providers are required to be certified by CMS. FQHCs providing laboratory services must supply a CLIA certificate at credentialing and recredentialing.
- RHC providers are licensed by DHEC. RHC providers must be certified by CMS. RHCs providing laboratory services must supply a CLIA certificate at credentialing and recredentialing.
- Alcohol and substance use clinics are licensed by DHEC.
- Portable X-ray providers are to be surveyed by DHEC. Portable X-ray providers are required to be certified by CMS.
- Stationary X-ray equipment is to be registered with DHEC.
- Physiology lab providers are to be enrolled with Medicare.
- Mammography service facilities providers are to be certified by the FDA.
- Mail order pharmacies are licensed by the appropriate state board. Out-of-state mail order pharmacy providers are required to have a nonresident South Carolina permit issued by the South Carolina Board of Pharmacy.
  - Home health service providers are to be licensed and surveyed by the DHEC. Home health service providers must be certified by CMS.
  - Long-term care facilities/nursing homes are to be surveyed and licensed under state law. Long-term care facilities/ nursing homes are required to be certified by DHEC.
  - Humana Healthy Horizons will credential South Carolina state agencies and organizations rather than each individual provider employed at the agency/organization. Such agencies and organizations include the Department of Alcohol and Other Drug Abuse, the Department of Mental Health, the Department of Social Services (DSS), 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 recredentialing

Network providers, including practitioners and organizational providers, are recredentialed at least every 3 years. As part of the recredentialing process, Humana Healthy Horizons considers information regarding performance to include complaints, safety and quality issues collected through the quality improvement program. Additionally, information regarding adverse actions is collected from the National Practitioner Data Bank (NPDB), Medicare and Medicaid sanctions, the CMS Preclusion List, HHS-OIG, GSA (formerly EPLS), and limitations on licensure.

Practitioner rights

- Practitioners have the right to review, on request, information submitted to support their credentialing application to the Humana Healthy Horizons credentialing department. Humana Healthy Horizons 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 recredentialing 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 recredentialing application on written request to the credentialing department.
- Humana does not make credentialing decisions based on an applicant's race, ethnic/national identity, gender, age, or sexual orientation or on type of procedure or patient (e.g., Medicaid) in which a practitioner or organizational provider specializes. Humana does not discriminate against a provider on the basis of the practitioner's license or certification or because the provider services high-risk populations and/or specializes in the treatment of costly conditions.
- Monitoring for and the prevention of potential discriminatory credentialing and recredentialing decisions should be evaluated at least annually. To identify potential discrimination, the Credentialing Operations Department reviews the reason for denying practitioner or organizational provider. Instances of potential discrimination discovered during this process are referred to the corporate quality improvement committee for review and decision

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 Healthy Horizons initiates immediate action in the event that the participation criteria are no longer met. Network providers are required to inform Humana Healthy Horizons of changes in status, including being named in a medical malpractice suit; involuntary changes in hospital privileges, licensure or board certification; an event reportable to the NPDB; federal, state or local sanctions; or complaints.

Delegation of credentialing/recredentialing

Humana Healthy Horizons will only enter into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated is accredited by NCQA for these functions or

adheres to NCQA standards and successfully passes a predelegation audit demonstrating compliance with NCQA and federal and state requirements. A predelegation audit must be completed prior to entering into a delegated agreement. All preassessment evaluations are performed utilizing the most current NCQA and regulatory requirements. The following will be included (at a minimum) in the review:

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

Subcontractors (delegates) 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/recredentialing decisions

Humana Healthy Horizons' 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 calendar days of the notification. Reconsideration opportunities are available to providers if they are affected by an adverse determination. To submit a reconsideration request, the following steps apply:

Email a reconsideration request to the senior medical director. A reconsideration request must be in writing and include any additional supporting documentation.

Send an email to: **dadwell@humana.com**

Use the following subject line: Request for Reconsideration

On reconsideration, the credentialing committee may affirm, modify or reverse its initial decision. Humana Healthy Horizons notifies the applicant, in writing, of the Credentials Committee's reconsideration decision within 30 calendar 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 to 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 email address above for reconsideration by the credentialing committee.

Chapter 17: Delegated services, policies and procedures

Scope

The guidelines and responsibilities outlined in this appendix are applicable to all Humana Healthy Horizons subcontractors (delegates). The information provided is designed primarily for the subcontractor's administrative staff responsible for the implementation or administration of certain functions that Humana Healthy Horizons has delegated to an entity.

Overview

Humana Healthy Horizons 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 healthcare providers and facilities
- Provision of clinical health services, such as UM and population health management
- Claim adjudication and payment
- Inquiries in the medical and managed behavioral healthcare organization setting

Contact the local Humana Healthy Horizons market office provider representative for detailed information on delegation, or call Provider Services at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

Subcontractors must comply with the responsibilities outlined in the Delegated services, policies and procedures section of this manual. This document is available from the local Humana market office or by calling 800-626-2741, Monday through Friday, 9 a.m. to 6 p.m., Eastern time.

Oversight

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

The delegation process begins with Humana Healthy Horizons performing a predelegation audit prior to any function being delegated to a prospective subcontractor. After approval and execution of a

delegation agreement, Humana Healthy Horizons performs an annual audit on an ongoing basis until the delegation agreement is terminated.

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

- Ability to perform the delegated function(s), compliance with accreditation organization standards, state and federal rules, laws and regulations, Humana Healthy Horizons policies and procedures, as well as the subcontractor's underlying contractual requirements pertaining to the provision of healthcare services
- Financial soundness (if delegated for claim adjudication and payment)

Humana Healthy Horizons continues to monitor all subcontractors through the collection of periodic reporting outlined within the delegation agreement. Humana Healthy Horizons provides the templates and submission process for each report. In addition, reporting requirements may change to comply with NCQA accreditation standards, state and federal requirements or Humana Healthy Horizons standards. Any changes are communicated to the subcontractor at such time.

Corrective action plans

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

Subdelegation

The delegate must have Humana Healthy Horizons' prior written approval for any subdelegation by the subcontractor of any functions and/or activities and notify Humana Healthy Horizon of any changes to functions being delegated including offshore locations.

The subcontractor must provide Humana Healthy Horizons with documentation of the predelegation audit that they performed of their subcontractor ensuring compliance with the functions and/or activities to be delegated.

Please note: State Medicaid contracts generally prohibit Medicaid member data from leaving the United States or U.S. territories, so any form of subdelegation must be approved by the appropriate Medicaid and regulatory compliance team.

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 PHI in oral, written or electronic form.

If Humana Healthy Horizons approves the subdelegation, the delegate will provide Humana Healthy Horizons with documentation of a written subdelegation agreement that:

- Is mutually agreed upon
- Describes the activities and responsibilities of the delegate and the subdelegate
- Requires at least semiannual reporting of the subdelegate to the delegate
- Describes the process by which the delegate evaluates the subdelegate's performance
- Describes the remedies available to the delegate if the subdelegate does not fulfill its obligations, including revocation of the delegation agreement
- Allows Humana Healthy Horizons 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 Healthy Horizons' and the subcontractor's requirements, state and federal rules, laws and regulations, and NCQA accreditation organization standards, and is subject to the terms of the written agreement between Humana Healthy Horizons and the subcontractor
- Retains Humana Healthy Horizons' right to perform evaluation and oversight of the subcontractor

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

The subcontractor agrees to monitor its subdelegate for federal and state government program exclusions on a monthly basis for 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, that provider, subcontractor or employee is immediately removed from providing direct or indirect services for Humana Healthy Horizons members.

Delegation requirements

The subcontractor must comply with the following requirements:

- Submit any material change in the performance of delegated functions to Humana Healthy Horizons for review and approval, prior to the effective date of the proposed changes.
- Obtain and maintain, in good standing, a third-party administrator (TPA) license/certificate and/or a utilization review license or certification if required by state and/or federal law, rule or regulation.

- Ensure that personnel who carry out the delegated services have appropriate training, licensure and/or certification.
- Adhere to Humana Healthy Horizons' record retention policy for all delegated function documents, which is 10 years (the same as the CMS requirement).
- Use Humana Healthy Horizons member templates for all member communications. Delegate must implement any updates to templates within 30 calendar days of notification of updates from Humana Healthy Horizons.
- 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.

Utilization management delegation

Delegation of 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.

All delegates performing UM activities must comply with and meet the rules and requirements for processing UM requests established or implemented by the state. In addition, they must conduct all UM activities in accordance with NCQA standards, the member's plan and Humana Healthy Horizons' policies and procedures. Humana Healthy Horizons retains the right and final authority to review decisions for its members regardless of any delegation of such functions or activities to delegate. Refer to your delegation agreement for specifics.

The delegate is to conduct the following functions regarding initial determinations:

- 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.
- Utilize Humana Healthy Horizons' PAL, which is posted on **Provider.Humana.com/coverage-claims/prior- authorizations/prior-authorization-lists**. If the subcontractor is delegated for both UM and claim payment, the subcontractor may develop its own PAL. However, the subcontractor's PAL may not be more stringent than Humana Healthy Horizons' PAL. If the subcontractor is not delegated to process claims on Humana Healthy Horizons' behalf, the subcontractor must utilize Humana Health Horizons' PAL.
- Perform preadmission review and authorization, including medical necessity determinations based on approved criteria, specific benefits and member eligibility.
- Perform UM activities for outpatient/ambulatory care.

- For concurrent review activities relevant to inpatient and skilled nursing facility stays, the subcontractor should:
  - Provide on-site or telephone review for continued stay assessment using approved criteria
  - Identify potential quality of care concerns, including sentinel events and never events, and notification to the local health plan for review within 24 hours of identification or per contract
  - Provide continued stay determinations
  - Notify member, facility and provider of decision on concurrent determination
  - Perform discharge planning and retrospective review activities
- Perform retrospective reviews, UM activities for out-of-service areas and out-of-network providers, and discharge planning as dictated by the contract.
- Notify the member, facility and provider of the decision on initial determinations using Humana Healthy Horizons' approved letter templates.
- Perform UM activities for out-of-service areas and out-of-network providers as dictated by the contract.
- Expedite determinations (as required) and maintain an expedited determinations log.
- For adverse determinations, maintain a denial log and submit as required by regulatory and accreditation organization requirements. Humana Healthy Horizons retains the right to make the final decision regardless of contract type.
- Maintain documentation of pertinent clinical information gathered to support the decision.
- Understand that all UM files and supporting documentation are Humana Healthy Horizons' property. Should the contract between the delegate and Humana Healthy Horizons be dissolved for any reason, the delegate is expected to make available to Humana Healthy Horizons either the original or quality copies of all UM files for Humana Healthy Horizons members.

Humana Healthy Horizons does not delegate quality of care determinations.

Humana Healthy Horizons performs this function when review decisions by a delegate are not timely, are contrary to medical necessity criteria and/or when Humana Healthy Horizons must resolve a disagreement between a delegate, providers and a member. In some local health plans, Humana Healthy Horizons may assume total responsibility for this function. Refer to your delegation agreement for specifics.

Claim delegation

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

Regarding claims performance requirements, all delegates performing claim processing must comply with and meet the rules and requirements for the processing of Medicaid claims established or implemented by the state.

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

- Subcontractor must accurately process all delegated claims according to Humana Healthy Horizons' requirements and in accordance with state and federal laws, rules and regulations, and/or any regulatory or accrediting entity to which Humana Healthy Horizons is subject.
- The subcontractor must pay any and all interest amounts on claims in accordance with applicable state and federal requirements.
- The subcontractor must maintain an accuracy rate of 99% of total dollars paid, for any given calendar month.
- Notify the member, facility and provider of any claims that have been denied.
- Since Humana Healthy Horizons does not delegate nonparticipating provider reconsideration requests, the delegate should forward all requests to Humana Healthy Horizons upon receipt.
- Subcontractor shall provide a financial guarantee, acceptable to Humana Healthy Horizons, prior to implementation of any delegation of claim processing, such as a letter of credit, to ensure its continued financial solvency and ability to adjudicate and process claims. The delegate shall submit appropriate financial information upon request as proof of its continued financial solvency.
- Subcontractor shall supply staff and systems required to provide claim and encounter data to Humana Healthy Horizons as required by state and federal rules, regulations and Humana Healthy Horizons. Refer to the Process Integration Agreement for details.
- Delegate shall retain and maintain legal, claims and encounter documents for the period of time and in the manner required by state and federal law or Humana Healthy Horizons, including without limitation HIPAA and/or any requirements of regulatory or accreditation organization to which Humana Healthy Horizons is subject, whether voluntarily or not.
- Subcontractor should use and maintain a claim 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.
- The delegate must make available as requested by Humana Healthy Horizons all original files, records and documentation pertaining to Humana Healthy Horizons members, or copies thereof on the termination of the performance of delegated functions and/or the expiration, nonrenewal or termination of the agreement, regardless of the cause.

Credentialing delegation

The delegate agrees that upon the termination of the delegated function, any files, records and documentation or quality copies of such files and documentation pertaining to Humana participating providers, which is necessary for Humana to resume responsibility for the delegated function, will be made available to Humana prior to termination of the function or at a minimum 15 business days after such termination.

This includes maintaining a credentialing committee, a credentialing and recredentialing program and all related policies, procedures and processes in compliance with these requirements.

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

Reporting requirements

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

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

The subcontractor agrees that upon the termination of the delegated function, any files, records and documentation or quality copies of such files and documentation pertaining to Humana Healthy Horizons participating providers, which is necessary for Humana Healthy Horizons to resume responsibility for the delegated function, will be made available to Humana Healthy Horizons prior to termination of the function or at a minimum 15 business days after such termination.

Appeals and grievances

Humana Healthy Horizons maintains all member rights and responsibility functions except in certain special circumstances. Therefore, the subcontractor must:

- Forward all standard member appeals/grievances to Humana Healthy Horizons within one business day:

  Phone: 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time

  Fax: 800-949-2961

- Forward all expedited appeals immediately on notification/receipt:

  Phone: 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time

  Fax: 800-949-2961

- Provide the following information when forwarding member appeals or grievances: date and time of receipt, member information, summary of the appeal or grievance, all denial information and summary of any actions taken, if applicable.
- Effectuate promptly the appeal decision as rendered by Humana Healthy Horizons and support any requests received from Humana Healthy Horizons 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 nonparticipating provider appeals for claim payment and denials.

Definitions

Abuse—Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to the Medicaid program or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. This 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:

- 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
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner, as defined by the state
- The failure of an MCO, prepaid inpatient health plan or prepaid ambulatory health plan to act within the time frames provided in 42 CFR Section 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals
- For a resident of a rural area with only one MCO, the denial of a member's request to exercise the member's right, under 42 CFR Section 438.52(b)(2)(ii), to obtain services outside the network
- 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 Section 422.113(a)).

Appeal—A request for review of an adverse benefit determination, as defined in 42 CFR Section 438.400.

Authorized representative—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 and 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 disorder and/or substance use disorder prevention in treatment for the purpose of providing comprehensive services.

Benefit or benefits—The healthcare services set forth in which Humana Healthy Horizons has agreed to provide, arrange and be held fiscally responsible. This also is referenced as core benefits or covered services.

Business days—Monday through Friday, 9 a.m. to 5 p.m., Eastern time, excluding state holidays.

Calendar days—All 7 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 healthcare needs and services of Medicaid managed care program members.

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

Care management—A set of activities designed to assist patients and their support systems in managing medical conditions and related psychosocial problems more effectively, with the aim 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 Healthy Horizons. This also is referred to as benefits or covered benefits.

Credentialing—Humana Healthy Horizons' determination as to the qualifications and ascribed privileges of a specific provider to render specific healthcare services.

Credible allegation of fraud—This may be an allegation that 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 the following:

- Fraud hotline complaints
- Claim data mining
- Patterns identified through provider audits, civil false claim 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 Section 438.206).

Disenroll/disenrollment/disenrolled—Action taken by a department or its designee to remove a Medicaid managed care program member from a plan following the receipt and approval of a written request for disenrollment or a determination made by the 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 or 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—A 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 any of the following:

- 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
- causing serious impairment to bodily functions
- causing 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
- 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 Healthy Horizons 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 Healthy Horizons and goes through an educational process to become a Medicaid managed care program member of Humana.

Evidence of Coverage—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. These are 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 providers, 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 that person or some other person. This includes any act that constitutes under applicable federal or state law.

Fraud, waste and abuse (FWA)—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—An expression of dissatisfaction about any matter other than an adverse benefit determination. Possible subjects for grievances include 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—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 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
- That does not account for credit for applicable discounts

Inquiry—A routine question 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, 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 their 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 HHS-OIG maintains the LEIE (List of Excluded Individuals and Entities), a database accessible to the general public that provides information about parties excluded from Medicare, Medicaid, and all other federal healthcare programs. The LEIE website is located at http://www.oig.hhs.gov/fraud/exclusion.asp and is available in two formats. The on-line search engine 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 may be compared against an existing database maintained by the Provider; however, the downloadable version does not contain SSNs or EINs.

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 of 2005 (DRA) and signed into law in February 2006 that created the MIP under Section 1936 of the Social Security Act, under which CMS hires contractors to review Medicaid provider activities, audit claims, identify overpayments and 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—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 policies and procedures.

Member—A Medicaid beneficiary who is currently enrolled in the state's Medicaid managed care program, specifically an MCO. Other managed care programs may include PIHP, PAHP or PCCM (42 CFR Section 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 the state contract, this term is used interchangeably with "member" and "beneficiary."

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

Noncovered services—Services not covered under the South Carolina State Plan for Medical Assistance.

Nonparticipating provider physician—A physician licensed to practice who has not contracted with or is not employed by Humana Healthy Horizons to provide healthcare services.

Outpatient services—Preventive, diagnostic, therapeutic, rehabilitative, surgical and 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 Healthy Horizons 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 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, OB-GYN 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 Healthy Horizons for specific services before rendering those services.

Procedure—For the purposes of this contract, 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 Section 160.103.

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

Quality assessment and performance improvement (QAPI)—Activities aimed at improving 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 Healthy Horizons 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)—Certified by CMS and receives public health services grants. An RHC is eligible for state-defined, cost-based reimbursement from the Medicaid fee-for-service program. An 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 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. This 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.

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
ACIP	Advisory Committee on Immunization Practices
ADA	Americans with Disabilities Act
AHRQ	Agency for Healthcare Research and Quality
ANSI	American National Standards Institute
ASAM	American Society of Addiction Medicine
ASC	Accredited Standards Committee
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective action plan
CDC	Centers for Disease Control and Prevention
CDL	Comprehensive drug list
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
CMSA	Case Management Society of America
CPT	Current Procedural Terminology
DAODAS	Department of Alcohol and Other Drug Abuse Services
DHHS	U.S. Department of Health & Human Services
DME	Durable medical equipment
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External quality review
EQRO	External quality review organization
FDA	Food and Drug Administration
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
FWA	Fraud, waste and abuse
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
ICM	Intensive case management
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disability
ID	Identification
LEIE	List of excluded individuals/entities
LTC	Long-term care
MCO	Managed care organization
MIP	Medicaid Integrity Program
MMIS	Medicaid Management Information System
MRFU	Medicaid Recipient Fraud Unit
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NPI	National Provider Identification
NPDB	National Practitioner Data Bank
OB-GYN	Obstetrics-gynecology
OIG	Office of Inspector General
P&T	Pharmacy and Therapeutics Committee
PAHP	Prepaid ambulatory health plan
PBM	Pharmacy benefits manager
PCCM	Primary care case management
PCP	Primary care provider
PHI	Protected health information
PI	Program Integrity
PIHP	Prepaid inpatient health plan
PIP	Performance Improvement Project
PRTF	Psychiatric Residential Treatment Facility
QAPI	Quality assessment and performance improvement

QI	Qualifying improvement
RHC	Rural Health Clinic
RN	Registered nurse
Rx	Prescription drugs
SC or S.C.	South Carolina
SCDHEC	South Carolina Department of Health and Environmental Control
SCDHHS	South Carolina Department of Health and Human Services
SIU	Special Investigations Unit
SPMI	Serious and persistent mental illness
SPLIP	Statewide pharmacy lock-in program
SUD	Substance use disorder
TCM	Targeted case management
TTY	Teletype
UB-04	Provider claim form (aka CMS 1450)
UM	Utilization management

HIDE-SNP Appendix Section 1: Introduction to Humana's HIDE-SNPs in South Carolina

About this appendix

In this appendix, you will find information about processes and requirements specific to Humana's Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) in South Carolina. Wherever applicable, we will refer back to our South Carolina Medicaid and Humana Dual Integrated Provider Manual or our Medicare Provider Manual, available at **Humana.com/Publications**, to streamline our provider educational materials.

This appendix is revised annually—and more often as needed—to provide new information and updates. The web-based version will represent the latest update.

About Humana's HIDE-SNPs in South Carolina

A HIDE-SNP is a type of Dual Eligible Special Needs Plan (D-SNP), which is a type of Medicare Advantage (MA) plan designed for individuals who are eligible for both Medicare and full Medicaid benefits. In addition to the Medicare plan benefits, HIDE-SNP members also receive all South Carolina Medicaid benefits under the Humana Healthy Horizons in South Carolina plan. HIDE-SNPs are an integrated type of D-SNP, offering coverage under a single legal entity that contracts with both Medicare and Medicaid. HIDE-SNPs provide a comprehensive range of services, including primary and acute care, behavioral health services and prescription drug coverage.

There are several other types of SNP products, as defined by CMS, which target different populations and member needs. This appendix applies only to Humana's HIDE-SNPs in South Carolina, Humana Dual Integrated HIDE H1396-001. All other SNP products are out of scope for this appendix, including all Humana Gold Plus plans and Humana Together in Health. If you are serving a member in one of these plans, and need more information, please refer to Humana's Medicare Manual on our website at **Humana.com/Publications.**

HIDE-SNPs offer many benefits to individuals who are eligible for both Medicaid and Medicare to facilitate their ability to navigate complex health insurance systems and receive the services and supports they need to thrive and live healthy lives. These benefits include:

- Receiving integrated and cobranded materials, such as member ID cards, benefit determinations, enrollment documents and provider directories

- Coordination of benefits across Medicaid and Medicare, including care management services (e.g., HIDE-SNP members have one care coordinator who manages both their Medicaid and Medicare benefits)
- Aligned enrollment with their Medicaid and Medicare coverage, meaning that their benefits are managed by the same health insurance company, which improves coordination and care management across Medicaid and Medicare benefits

Joining our network to serve HIDE-SNP members

If you are not yet participating in our network but are interested in joining, please reach out to us by calling Provider Services at: 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time or emailing one of the following email addresses, depending on your provider type:

- Physical health providers: **SCProviderUpdates@humana.com**
- Behavioral health providers: **SCBHMedicaid@humana.com**

To provide Medicare-covered services to HIDE-SNP members, you must enroll in our South Carolina Medicare Health Maintenance Organization (HMO) provider network. To provide Medicaid- covered services to our HIDE-SNP members, you must enroll in our South Carolina Medicaid provider network. To join our South Carolina Medicaid provider network, you must first enroll with SC Healthy Connections through their enrollment wizard at **https://providerservices.scdhhs.gov/ProviderEnrollmentWeb/**. Unless you only provide services that are only covered by Medicaid, we highly recommend that you enroll in both networks to improve access to care and continuity of care for your HIDE-SNP patients, as well as to optimize your experience. By enrolling in both networks, you will also be eligible to receive a single explanation of remittance and single payment from Medicaid and Medicare for your Humana HIDE-SNP-enrolled patients. However, you do not have to enroll in our Medicaid network to receive reimbursement for Medicare cost share amounts covered by Medicaid. Our contracting team will support you throughout the contracting and credentialing process to join both networks.

Before serving HIDE-SNP members, you must also be credentialed. For information about credentialing and recredentialing, you should refer to the **credentialing chapter** of the Medicaid portion of this manual as well as the credentialing section of our Medicare Provider Manual, available at **Humana.com/Publications**.

Helpful websites

Providers can obtain additional information and resources for Humana's HIDE-SNP in South Carolina by visiting **Humana.com/HealthySC** and **Humana.com/Publications**. Providers have access to:

- Claim resources
- Health and wellness program resources
- **Making it Easier tutorials**
- Medicare Provider Manual

- Pharmacy Provider Manual
- Provider publications (including newsletters and program updates)
- Quality resources
- South Carolina Medicaid and Humana Dual Integrated Provider Manual

For help or more information regarding web-based tools, please call Provider Services at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

You may also review the CMS website at **www.cms.gov** for more information on D-SNPs as well.

Provider portal

Humana has partnered with **Availity Essentials** to give providers access to member and claim data for multiple payers using one platform and login. With Availity Essentials, providers can:

- Submit claims and view claim status
- Check eligibility and benefits
- Submit and view authorizations and referrals
- Submit appeals
- View remittance advice
- Access electronic funds transfer (EFT) and electronic remittance advice (ERA) enrollment
- Access training

You should follow the same processes to perform any of the above functions for a Humana HIDE-SNP member as you would for a Humana Medicaid or Medicare member. For example, you may verify member eligibility for a Medicaid, Medicare or HIDE-SNP member by:

1. Signing in to **Availity Essentials**
2. Navigating Patient Registration
3. Selecting Eligibility and Benefits Inquiry

To learn more about Availity Essentials, call 800-282-4548, Monday through Friday, 8 a.m. to 8 p.m., Eastern time or visit **Availity.com**.

Accreditation

The National Committee for Quality Assurance (NCQA) review process examines Humana's quality improvement program structure; tests quality improvement processes and looks for evidence that quality improvement activities have resulted in measurable improvement in Humana's performance in both clinical and service areas. The NCQA Healthcare Effectiveness and Data Information Set (HEDIS®) is designed to measure plan and provider performance on several measures to produce a consumer report card. The information collected from managed care plans is published to assist consumers in choosing a healthcare plan, physicians and other healthcare providers. Specific HEDIS

measures may change annually to reflect medical advances and to identify new areas in which to focus improvement efforts.

Humana prepares information for NCQA based on data obtained from participating providers in the form of claims or encounter records. In addition to gathering HEDIS data administratively via claims and encounters, Humana also encourages submission of supplemental data. For example, one HEDIS measure is to determine if members with diabetes receive an annual dilated eye examination. The percentage of diabetic members who meet HEDIS criteria and have an encounter reported for a dilated retinal eye examination is reported. If there is no report of such an examination, the member is identified as needing an examination. Humana may remind members of the importance of the examination, assist in scheduling an appointment, or help overcome their barriers to receiving the examination. The type of outreach the member receives is based upon consumer insights and the history of completing a dilated eye examination. Periodically, the Humana quality management department may visit provider offices to review medical records of members and to collect data.

URAC® (originally known as Utilization Review Accreditation Commission) is a nonprofit organization founded in 1990 to establish standards for the healthcare industry by providing a method of evaluation and accreditation for a variety of healthcare organizations, including health plans, utilization management organizations, pharmacy benefit managers and others. There are more than 20 accreditation and certification programs—some that review the entire organization, such as the health plan standards, and some that focus on a single functional area in an organization, such as case management or credentialing. Any organization that meets the standards, including hospitals, HMOs, preferred provider organizations (PPOs), TPAs and provider groups, can seek accreditation.

HIDE-SNP Appendix Section 2: Member eligibility and enrollment

Member eligibility

Humana's HIDE-SNP in South Carolina offers plans to dually eligible Medicaid and Medicare members to provide coverage for the Medicare services; and enrolls individuals who are entitled to benefits under Medicare Parts A and B and are eligible to receive full Medicaid benefits through South Carolina's Managed Care Medicaid program. This includes Full Benefit Dual Eligible (FBDE) members such as:

- **Qualified Medicare Beneficiary Plus (QMB+):** An individual who is entitled to Medicare and meets the federal income standard of income equal to or less than 100% of the federal poverty level (FPL) and is determined eligible for full Medicaid coverage.
- **Special Low Income Medicare Beneficiary Plus (SLMB+):** An individual who is entitled to Medicare and meets the federal income standard of income greater than 100% but less than 120% of the FPL and who also meets though a spend-down.
- **Other FBDE:** An individual who is entitled to Medicare, does not meet the income or resource criteria for QMB+ or SLMB+, but is eligible for full Medicaid coverage either categorically or through optional coverage groups based on Medically Needy status, special income levels for institutionalized individuals, or home and community-based waivers.

All Humana HIDE-SNP members are protected from balance billing, meaning that they may not be billed or charged any coinsurance or copay for any covered services provided.

By enrolling in Humana's HIDE-SNP, dual-eligible individuals can receive both of their Medicare and Medicaid benefits under one plan. Medicare is available to people who are age 65 or older, younger than 65 with a qualifying disability, or have end stage renal disease, permanent kidney failure requiring dialysis or a kidney transplant. To review eligibility information for South Carolina's Managed Care Medicaid program, please review the **member enrollment and eligibility chapter of the Medicaid portion of this manual**.

Deeming period

If a member experiences changes to their Medicaid eligibility level or loses Medicaid eligibility, the member is placed into the deeming period. During the deeming period, the Medicare HIDE-SNP benefits and PCP remain the same; however, the member does not have any Medicaid benefits. During the time the member is in the deeming period, the amount applied to cost share will be paid under the Humana Medicare plan. Members have up to 6 months to regain qualifying Medicaid

eligibility and remain in the HIDE-SNP. If the member does not regain qualifying Medicaid eligibility during those 6 months, they will be disenrolled from the HIDE-SNP. As a reminder, you are encouraged to verify a patient's eligibility via **Availity Essentials** before providing services.

Verifying member eligibility

Before providing all nonemergency services, you must verify member eligibility. You should ask members to present an ID card each time services are rendered. If you are not familiar with the member seeking care and cannot verify the person as a Humana member, you should ask to see photo ID. Eligibility can be verified by logging into **Availity Essentials** > Patient Registration > Eligibility and Benefits Inquiry.

Member enrollment

Members can enroll into a Humana HIDE-SNP by working with a third-party enrollment broker, called South Carolina Healthy Connections Choices (SCHCC). Eligibility begins on the first day of each calendar month for members joining Humana.

Members with a residential address in one of the following 46 counties may enroll in our Humana HIDE-SNP:

Abbeville

Aiken

Allendale

Anderson

Bamberg

Barnwell

Beaufort

Berkeley

Calhoun

Charleston

Cherokee

Chester

Chesterfield

Clarendon

Colleton

Darlington

Dillon

Dorchester

Edgefield
Fairfield
Florence
Georgetown
Greenville
Greenwood
Hampton
Horry
Jasper
Kershaw
Lancaster
Laurens
Lee
Lexington
Marion
Marlboro
McCormick
Newberry
Oconee
Orangeburg
Pickens
Richland
Saluda
Spartanburg
Sumter
Union
Williamsburg
York

Exclusively aligned enrollment

Exclusively aligned enrollment means the full dual eligible member's D-SNP Medicare plan provider is the same as the member's Medicaid MCO. The member has Humana for both their Medicare and their Medicaid benefits, so when a member enrolls in the Humana HIDE-SNP, the state automatically enrolls them into the Humana plan within a month of their enrollment in our HIDE-SNP.

PCP choice and assignment

Humana offers each HIDE-SNP member the opportunity to choose a Humana-affiliated PCP to the extent open panel slots are available. HIDE-SNP members can select a PCP from our integrated provider directory, inclusive of Medicaid and Medicare providers, at **Humana.com/FindADoctor**. If eligible members do not request an available PCP prior to the 25th day of the month prior to the effective enrollment date, then Humana assigns the new member to a PCP within our network, taking into consideration known factors such as:

- Current or past provider relationships
- Language needs
- Age and sex
- Enrollment of family members (e.g., siblings)
- Area of residence

Humana notifies the member in writing, on or before the effective date of enrollment with Humana, of their PCP's name, location and office phone number.

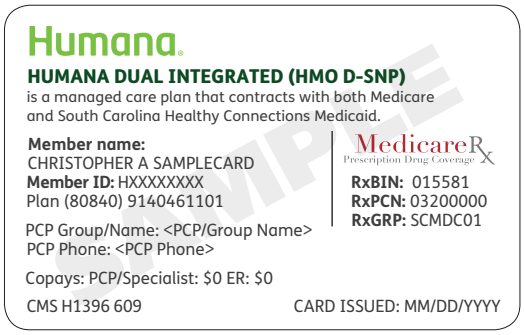
PCP changes

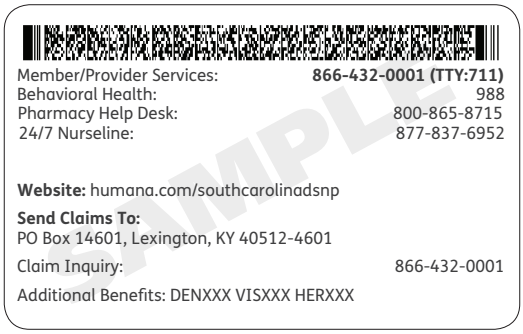
Members have the option to change to another participating PCP as often as needed. PCP changes are effective on the first day of the month following the requested change. Humana members can select a new PCP or be assigned one by request when Humana has terminated a PCP or when a PCP change is ordered as a part of the resolution to a formal grievance proceeding. When a member changes PCPs, Humana helps with ensuring the member's medical records or copies of them are available to their new PCP within 10 business days from receipt of the medical record request.

Member ID cards

All new Humana HIDE-SNP members receive a single, integrated member ID card. Humana HIDE-SNP members do not need separate ID cards for Medicaid and Medicare. A new card is issued only if the information on the card changes, the card is lost, or an additional card is requested. The member ID card is used to identify a Humana member but does not guarantee eligibility or benefits coverage because members may disenroll from Humana or lose Medicaid eligibility at any time. Therefore, it is important to verify member eligibility prior to rendering any service. Sample images of the Humana HIDE-SNP member ID cards are included below:

Sample Humana Dual Integrated member ID card front and back:





If a member requires a new ID card, they can call Member Services at 866-432-0001 (TTY: 711), 7 days a week, 8 a.m. to 8 p.m., Eastern time.

Member welcome kit

Each new member receives a new member kit and an ID card. New member kits are mailed separately from the ID card. The new member kit contains:

- Quick start guide booklet
- Summary of benefits
- Introduction letter
- Applicable member forms and a postage-paid return envelope for ease of returning forms
- A hard copy notice that includes information on how to locate online or how to request a one- time printed copy of plan materials (e.g., member handbook [evidence of coverage], list of covered drugs [drug list or formulary], provider and pharmacy directory)

Member disenrollment

Members may be disenrolled from Humana for several reasons. Humana, the state, or CMS can initiate disenrollment, which may be initiated for the following:

- Unauthorized use of a member ID card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the ability to deliver care to the member or to other patients
- Death of member
- Loss of Medicare entitlement to Part A and/or Part B
- Humana's contract is terminated, or Humana reduces its service area, excluding the member
- Members permanently move outside the service area, are away from the service area for more than 6 consecutive months, or are incarcerated and, therefore, out of the area

- The HIDE-SNP member loses special needs status and does not re-establish HIDE-SNP eligibility prior to the expiration of the period of deemed continued eligibility

Please notify Provider Services at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time if one or more of these situations occur.

Medicare disenrollment for cause

CMS guidelines allow a PCP to request a member's disenrollment "for cause" only if the member's behavior is disruptive, unruly, abusive, threatening or uncooperative to the extent that his/her continued membership would substantially impair the provider's ability to provide health services to that member or other patients. A member also may be disenrolled for other reasons including, but not limited to, if he/she fails to qualify for Medicare benefits or fraudulently permits others to use his/her member ID card for services. A member cannot be disenrolled based on the member's utilization (or lack of use) of services or because of mental or cognitive conditions (including mental illness and developmental disabilities), disagreement with a provider regarding treatment decisions, or as retaliation for a member's complaint, appeal or grievance. Before initiating a request to disenroll a member for cause, the provider and Humana must make a serious effort to resolve the problems, such as encouraging the member to change his/her behavior and must document the result of this action. If the behavioral problems are not resolved, the provider may initiate a request to disenroll the member by submitting the Request for Disenrollment for Cause letter/form by emailing **SCProviderUpdates@humana.com**.

CMS requires Humana to notify a D-SNP member that the consequences of continued disruptive behavior could include disenrollment from the plan. The health plan and provider must reasonably demonstrate that the member's behavior is not related to the use of prescribed medications, mental illness or cognitive conditions (including mental illness and developmental disabilities), treatment for a medical condition or use (or lack of use) of the provider's medical services.

Out of area

When a member is temporarily out of the service area (for up to 6 months) coverage is limited to urgently needed, emergency care, post-stabilization services following an emergency and renal dialysis until the member returns to the service area or the effective date of disenrollment. HIDE-SNP PPO members may receive participating benefits from any participating provider, nationwide, as well as out-of-network benefits.

Disenrollment outside of the service area: A member must notify a customer care representative when they permanently move out of the service area. A permanent move is an absence of more than 6 months.

HIDE-SNP Appendix Section 3: Member rights and responsibilities

Humana requires our staff and affiliated providers to comply with any applicable federal and state laws that pertain to member rights. Humana complies with:

- Title VI of the Civil Rights Act of 1964 as implemented at 45 CFR Part 80
- The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR Part 91
- The Rehabilitation Act of 1973
- Title IX of the Education Amendments of 1972 (regarding education programs and activities)
- Titles II and III of the Americans with Disabilities Act
- Section 1557 of the Patient Protection and Affordable Care Act
- All federal and state laws and regulations regarding privacy and confidentiality
- Rules of accrediting and regulatory agencies concerning member rights

The rights and responsibilities listed below, though not intended to be exhaustive, remind members and providers of their complementary roles in maintaining a productive relationship.

Member rights

Members have the right to:

- Be free from discrimination based on race, color, ethnic or national origin, age, sex, sexual orientation, gender identity and expression, religion, political beliefs, marital status, pregnancy or childbirth, health status or disability
- Be treated with courtesy and respect, with appreciation for their dignity and protection of their right to privacy
- Understand the healthcare information they receive
- Interpretation, written translation and auxiliary aids are available at no cost
- Access healthcare and services in a timely, coordinated and culturally competent way
- Receive information from their provider and health plan about treatment choices and have a candid discussion of appropriate or medically necessary treatment options, regardless of cost or benefit coverage
- Participate with providers in all decisions about their healthcare, including the right to say “no” to any treatment offered

- Ask their health plan for help if their provider does not offer a service because of moral or religious reasons
- Discuss their medical record with their physician and receive, upon request, a copy of that record and ask for it to be changed or corrected in accordance with state and federal law
- Have their medical records and treatment be confidential and private
  - Humana will only release their information if it is allowed under federal or state law or if it is required to monitor quality of care or protect against fraud, waste and abuse.
- Live safely in the setting of their choice
- If a member or someone they know is being abused, neglected or financially taken advantage of, they should call their local DSS or South Carolina DSS at 800-768-5858, Monday – Friday, 9 a.m. – 6 p.m., Eastern time
- Receive information on their rights and responsibilities and exercise their rights without being treated poorly by their providers, Humana or SCHCC
- Make recommendations regarding the member rights and responsibilities policy
- Be free from any restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- File appeals and complaints and ask for a State Fair Hearing
- Exercise any other rights guaranteed by federal or state laws (e.g., ADA)
- Be provided with information about their plan, its services and benefits, its providers and the rights and responsibilities of members
- Choose a PCP from our network of affiliated providers and change to another PCP in the Humana network
- Request a practitioner that has the same race, ethnicity and/or language as themselves if there is a practitioner available in their network
- Have a candid discussion with their provider about appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Expect reasonable access to medically necessary healthcare services, regardless of gender, race, national origin, religion, physical abilities or source payment
- File a formal complaint or appeal, as outlined in Humana's grievance procedure, and expect a response to that complaint within a reasonable period
- Expect Humana to adhere to all privacy and confidentiality policies and procedures
- Receive services that are provided in a culturally competent manner
- Receive treatment for any emergency medical condition
- Select an in-network provider and not be balanced billed for medically necessary covered services
- Receive an EOB and discuss that EOB with Humana
- File a claim or have a claim filed by a provider on their behalf

- Request and receive an organization determination from Humana regarding the services or treatment being requested, if members disagree with their physician about a denial of service
- Expect Humana to refer to the **South Carolina Department on Aging (SCDOA) Ombudsman's office** at whenever additional assistance and/or education regarding their Medicaid benefits and rights is required.

Member responsibilities

Members have the responsibility of:

- Follow their member handbook, understand their rights and ask questions when they do not understand or want to learn more
- Treat their providers, Humana staff and other members with respect and dignity
- Choose their PCP and, if needed, change their PCP
- Schedule appointments, arrive on time for scheduled visits and notify their healthcare provider if they must cancel or be late for a scheduled appointment
- Always carry their Humana ID card with them and use it while enrolled in the plan, including by showing it whenever they get care and services
- Give the plan and their healthcare provider (to the best of their ability) complete and accurate information needed for their care about their medical history and their symptoms
- Understand their health problems and participate in developing agreed-upon treatment goals with their healthcare provider
- Work with their care coordinator and care team to create and follow a care plan that is best for them
- Invite people to their care team who will be helpful and supportive to be included in their treatment
- Tell Humana when they need to change their care plan
- Get covered services from the Humana network when possible
- Get approval from Humana for services that require a service authorization
- Use the emergency room for emergencies only
- Pay for services they get that are not covered by Humana or SCHCC
- Report on suspected fraud, waste and abuse
- Call Humana Member Services at 866-432-0001, 7 days a week, 8 a.m. to 8 p.m., Eastern time to let them know if:
  - Their name, address, phone number or email have changed
  - Their health insurance changes (from their employer or workers' compensation, for example) or they have liability claims, like from a car accident
  - Their member ID card is damaged, lost or stolen

- Read and be aware of all material distributed by the plan explaining policies and procedures regarding services and benefits
- Obtain and carefully consider all information they may need or desire to give informed consent for a procedure or treatment
- Be considerate and cooperative in dealing with Humana providers and respect the rights of fellow members
- Express opinions, concerns or complaints in a constructive manner
- Inform Humana of any change in their contact information, such as address or phone number, even if these changes are only temporary
- Follow healthcare facility rules and regulations affecting patient care and conduct
- Follow the plans and instructions for care that they have agreed upon with their providers

HIDE-SNP Appendix Section 4: Provider rights and responsibilities

Provider responsibilities and responsibilities overview

You are expected to treat members with respect. Our members should not be treated differently than patients with other healthcare insurance. For more information, please refer to the **provider rights and responsibilities chapter of the Medicaid portion of this manual**. A variety of topics are covered such as:

- ADA requirements
- Nondiscrimination
- Advanced directives
- HIPAA
- Provider training, including information on Cultural Competency and Health, Safety and Welfare trainings
- Identifying and reporting member abuse, neglect and exploitation
- Member billing/missed appointments

Critical incident reporting

You also have the responsibility to report critical incidents. For information on reporting critical incidents, please refer to the **quality management chapter of the Medicaid portion of this manual**.

Access to care standards

Providers in our Medicaid provider network must comply with Medicaid access to care standards as outlined in the **provider rights and responsibilities chapter of the Medicaid portion of this manual**. Providers in our Medicare provider network must implement procedures and make reasonable efforts to ensure that:

- Patients are seen by a clinician within 15 minutes of the patient's appointment time.
- Routine and follow-up appointments are made within 30 calendar days.
- Urgent appointments are made within 24 hours, 7 days a week.
- Urgently needed services are provided immediately for Medicare members.

- Emergency appointments are made immediately (arrange for on-call or after-hours coverage), 24 hours a day, 7 days a week.
- The standards consider the members' need and common waiting times for comparable services in the community. Examples of reasonable standards for primary care services are:
  - Urgent or emergency services – immediately.
  - Services that are not emergency or urgently needed, but in need of medical attention – within 1 week; and
  - Routine and preventive care – within 30 days.

Providers in both our Medicaid and Medicare provider networks must comply with both our Medicaid and Medicare access to care standards.

Provider training

In addition to the training requirements and resources outlined in the **provider rights and responsibilities chapter of the Medicaid portion of this manual**, providers serving HIDE-SNP members must complete our Special Needs Plans Training for Physicians annually, which covers an overview of the model of care. To learn how to access the training and obtain additional information about the model, please refer to **Humana.com/ProviderCompliance**.

Identifying and reporting fraud, waste and abuse

For information on identifying and reporting fraud, waste and abuse, please review the **fraud, waste and abuse chapter of the Medicaid portion of this manual**.

Marketing

Marketing and promotional activities, including provider promotional activities, must comply with all relevant federal and state laws, including, when applicable, the antikickback statute, which is a civil monetary penalty prohibiting inducements to members.

For purposes of this manual, the term "Medicare marketing and communication" includes any information, whether oral or written, intended to promote or educate prospective or current Humana Medicare Advantage or prescription drug plan members about Humana or its Medicare plans, products or services. This includes, but is not limited to, all promotional materials used at provider-sponsored activities, such as open houses, health fairs and grand openings. Examples of promotional materials include letters, advertisements, invitations and announcements that use Humana's name.

Medicare marketing and communication must be approved through the Humana corporate review process prior to a provider conducting any Medicare marketing and communication activity. The Humana corporate review process includes review by legal and regulatory compliance and filing through Humana's Medicare product compliance department and CMS (as applicable), in accordance with CMS guidelines. All marketing materials must be reviewed and approval by SDHHS through the Health Plan Management System (HPMS) system prior to distribution.

To obtain approved Medicare marketing or communication materials, contact your Humana representative or to arrange for a provider-sponsored activity, contact the regional Medicare sales director or physician marketing contact. Any joint (provider and plan) communication or marketing activity must also comply with Humana policies and procedures, as well as federal and state regulations. For applicable Humana policies, please see Humana's compliance policy. Any misrepresentation of a Humana Medicare product or service, intentional or not, is a serious violation of Humana's agreements with CMS.

You may announce new or continuing affiliations for specific sponsors of Medicare Advantage or prescription drug plans through direct mail, email, telephone or advertisement using Humana-approved templates. You may not create your own communications for this purpose or alter the templates in any way unless approved through the Humana corporate review process. Humana must review the communication prior to you sending it to ensure that it adheres to the approved template or that the communication has been approved through the Humana corporate review process. The announcement must clearly state that you also may contract with other plans/Part D sponsors. Any affiliation materials that describe plan benefits, premiums or cost sharing must be approved by Humana and CMS prior to use and may not be mailed by providers, as these would be considered marketing materials for a plan.

CMS requirements

Humana is responsible for including certain CMS MA-related provisions in the policies and procedures distributed to the providers that constitute Humana's health services delivery network. The following table summarizes these provisions, which can be accessed online by visiting Code of Federal Regulations on the U.S. Government Printing Office website at **https://www.ecfr.gov/**.

Summary of CMS requirements	CFR42 (section)
Safeguard privacy and maintain records accurately and timely	422.118
Permanent "out of area" members to receive benefits in continuation area	422.54(b)
Prohibition against discrimination based on health status	422.110(a)
Pay for emergency and urgently needed services	422.100(b)
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)
Direct access to mammography and influenza vaccinations	422.100(g)(1)
No copay for influenza and pneumococcal vaccines	422.100(g)(2)
Agreements with providers to demonstrate "adequate" access	422.112(a)(1)
Direct access to women's specialists for routine and preventive services	422.112(a)(3)
Services available 24 hours a day, 7 days week	422.112(a)(7)
Adhere to CMS marketing provisions	422.80(a), (b), (c)
Ensure services are provided in a culturally competent manner	422.112(a)(8)
Maintain procedures to inform members of follow-up care or provide training in self-care as necessary	422.112(b)(5)

Summary of CMS requirements	CFR42 (section)
Document in a prominent place of an individual's medical record if that individual has executed an advance directive	422.128(b)(1)(ii)(E)
Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)
Continuation of benefits provisions (may be met in several ways, including contract provision)	422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)
Payment and incentive arrangements specified	422.208
Subject to applicable federal laws	422.504(h)
Disclose to CMS all information necessary to (1) administer and evaluate the program (2) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services	422.64(a) 422.504(a)(4) 422.504(f)(2)
Must make good faith effort to notify all members affected by the termination of a provider contract 30 calendar days before their termination by plan or provider	422.111(e)
Submit data and medical records, and certify completeness and truthfulness	422.310(d)(3)-(4) 422.310(e) 422.504(d)-(e) 422.504(i)(3)-(4) 422.504(l)(3)
Comply with medical policy, quality improvement and medical management	422.202(b) 422.504(a)(5)
Disclose to CMS quality and performance indicators for plan benefits regarding disenrollment rates for beneficiaries enrolled in the plan for the previous two years	422.504(f)(2)(iv)(A)
Notify providers in writing for reason of denial, suspension and/or termination	422.202(d)(1)
Provide 60-day notice (terminating contract without cause)	422.202(d)(4)
Comply with federal laws and regulations including, but not limited to, federal criminal law, the False Claims Act (31 U.S.C. et Seq.) and the anti-kickback statute (section 1128B(b) of the act)	422.504(h)(1)
Prohibition of use of excluded practitioners	422.752(a)(8)
Adhere to appeals/grievance procedures	422.562(a)

List of provider rights and responsibilities

You should consider the following rights and responsibilities when caring for Humana HIDE-SNP members:

- Have a professional degree and a current, unrestricted license to practice medicine in the state in which your services are regularly performed.
- Agree to comply with Humana's quality assurance, quality investigation and peer review process, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by Humana.
- Be credentialed by Humana and meet all credentialing and recredentialing criteria as required.
- Not be on the HHS Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) or the General Service Administration's System of Award Management (SAM) debarment list.
- Not be on the CMS preclusion list (MA providers).
- 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 plan-member rounds and have no record of hospital privileges having been reduced, denied or limited, or if so, provide an explanation that is acceptable to the plan.
- 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, provider status (additions or deletions from provider practice), loss or decrease in amounts of liability insurance below the required limits and any other change that would affect your participation status with Humana.
- Not discriminate against members because of their participation as members, their source of payment, age, race, color, national origin, religion, sex, sexual preference, health status or disability.
- Not discriminate in any manner between Humana members and non-Humana 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, 7 days a week (required for HMO PCPs and all MA providers).
- Arrange for on-call and after-hours coverage by a participating and credentialed Humana physician (required for HMO PCPs and all MA providers).

- Refer Humana members with problems outside of your normal scope of practice for consultation and/or care to appropriate specialists contracted with Humana on a timely basis, except when participating providers are not reasonably available or in an emergency.
- Refer members only to participating providers, except in an emergency.
- Admit members only to participating in-network hospitals, SNFs 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 member, subscriber, or enrollee other than for copayments, deductibles, coinsurance, other fees that are the member's responsibility under the terms of their benefit plan, or fees for noncovered services furnished on a fee-for-service basis. Noncovered services are services not covered, or services excluded in the members' plan.
- For an MA plan member, you may only collect for a service not covered under the terms of the applicable member plan if you followed the procedures outlined in the utilization management/ preauthorization (prior authorization) section of Humana's Medicare Provider Manual at **https://provider.humana.com/working-with-us/publications**.
- 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 deaf and hearing impaired or blind or partially sighted) 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 & Human Services, Office of Minority Health at **https://thinkculturalhealth.hhs.gov/**.
- Provide access to healthcare benefits for all Humana members in a manner consistent with CMS requirements for any Humana MA member.
- For MA members who have end-stage renal disease (ESRD), complete the Chronic Renal Disease Medical Evidence Report, which is provided by the Social Security office when the provider becomes aware of the disease. The form must be completed and returned to the Social Security office and the ESRD Network. Fax the form to 502-508-3450 or mail the form to:

  Humana

  Attn: Medicare Reconciliation Department – ESRD Unit Waterside Building

  101 E. Main St.

  Louisville, KY 40202
- Provide or arrange for continued treatment to all members including, but not limited to, medication therapy, upon expiration or termination of the agreement.
- Help guarantee accessibility of services to members by maintaining a ratio of members to full-time equivalent (FTE) physicians as follows:
  - one physician FTE for 1,500 Medicaid members

- 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 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.
- Upon request of Humana, provide an electronic, automated means, at no cost, for Humana and all Humana-affiliated vendors acting on behalf of Humana 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 providers upon request and at no charge to Humana, the member or the requesting party, unless otherwise agreed upon.
- Provide copies of access to and the opportunity for Humana or its designee to examine your 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 and peer review obligations, as well as any 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 will be considered a breach of contract. For records related to Humana MA enrollees, this access right is for the time stipulated in the agreement or the time since the last audit, whichever is greater.
- To the extent applicable to the physician, assume full responsibility to the extent of the law when supervising/sponsoring, whether through a protocol, collaborative or some other type of agreement, physician assistants, advanced practice registered nurses, nurse practitioners 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 in order to treat members.
- Submit a report of an encounter for each visit when the member is seen by you. 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 consistent and in compliance with Humana's contractual obligations under its MA contract(s).

- Cooperate with and assist Humana in our efforts to comply with our MA contract(s) and/or MA rules and regulations and 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 of scheduled surgeries/procedures requiring inpatient hospitalization.
- Notify Humana of any material change in your performance of delegated functions, if applicable.
- Notify Humana of your termination 60 days prior to the effective date of termination.
- Not being excluded from participating in Medicare.
- Cooperate with an independent review of the organization's activities pertaining to the provision of services for Medicare members in an MA plan and 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 plan(s) with which you are contracted, including Humana's.
- Adhere to **Ethics Every Day for Contracted Healthcare Providers and Business Partners**.
- Understand and agree that nothing contained in the agreement or this manual is intended to interfere with or hinder communications between providers and members regarding a member's medical condition or available treatment options or to dictate medical judgment.
- For providers who participate in MA networks and who participate in Original Medicare, abide by the guidelines set out in Humana's Rules of Participation for MA Networks, which are **available here**. A paper copy can be obtained upon request.
- For providers who have downstream agreement(s) with physicians or other providers who provide services to Humana members, agree to provide a copy of said agreement(s) to Humana upon request (financial information is not requested).
- 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.
- Agree to 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.
- Not require members to select and pay for any type of "concierge medicine" program to receive services, items and/or benefits covered by the applicable Humana plan from the provider. Humana considers concierge medicine programs to include any practice management model under which a provider charges each patient a monthly, annual or other periodic fee in exchange for enhanced practice services over and above those services that are covered under the member's health

benefit plan, or charges such a fee before agreeing to provide any medical services to a patient. You may offer a concierge medicine program to members, provided that any such program meets the following requirements:

- You accept Humana's reimbursement as payment in full for all services that are covered services under the member's health benefit plan, and you are prohibited from holding Humana members liable for the payment of such services, except for member cost-sharing authorized under the plan.
- Any fees paid by members for your concierge medicine program cannot be in exchange for services that are covered services under the member's health benefit plan. You must be accessible and available to members consistent with Humana's participating provider requirements including, but not limited to, those requirements outlined in this manual, your participation agreement with Humana and those requirements outlined by any applicable state or federal law, including but not limited to those requirements outlined by CMS under the Medicare Managed Care Manual MMCM, Ch. 4, Section 110.1.1, regardless of whether a member chooses to participate in the provider's concierge medicine program. You should ensure that quality of care will not be adversely impacted if a member chooses not to participate in your concierge medicine program.
- You are prohibited from offering a concierge medicine program in any way that discriminates against members.
- A member's choice to participate in your concierge medicine program must be entirely voluntary. You are prohibited from inappropriately coercing or pressuring a member to participate in a concierge medicine program.
- Any concierge medicine program agreement with a member must: (a) inform the member that the program is optional and that they do not have to select and pay for the program to receive healthcare services from the provider that are covered services under their health benefit plan; (b) list the fee or fees and the added services, items and/or benefits included in the program; and (c) inform the member that the selection of, and payment for, the program is solely for services, items and/or benefits in addition to services that are covered services under their health benefit plan.

- Ensure confidentiality of family planning services in accordance with the Medicaid Contract, except to the extent required by law, including, but not limited to, the South Carolina Freedom of Information Act.
- As applicable, abide by the terms of the Medicaid contract for the timely provision of emergency and urgent care. Emergency services shall be available 24 hours a day, 7 days a week; urgent care appointments and symptomatic office visits shall be available as soon as the symptom demands but in no event more than 24 hours of the member's request. Where applicable, providers must agree to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of Understanding signed by Humana in accordance with the Medicaid Contract.

- Not creating barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered Medicaid services.
- Except in the case of death or illness, agree to notify Humana at least 30 days in advance of disenrollment and agree to continue care for your panel members for up to 30 days after such notification, until another provider is chosen or assigned.
- Meet Humana standards for licensure, certification and credentialing.
- In accordance with the requirements set forth in 1932(d)(6) and 1173(b) of the Social Security Act, each provider rendering covered services must have a unique NPI in accordance with the system set up under Section 1173(b) of the Social Security Act. This rule applies to all provider types and specialties.
  - Providers must use these identifiers when submitting data to Humana. The NPI is provided by CMS, which assigns the unique identifier through its National Plan and Provider Enumeration System.
- At the time of application to become part of Humana's network, credentialing and/or recredentialing and/or upon request from Humana, you must disclose required information for disclosure of ownership interests, business transactions and information on persons convicted of crimes related to any federal healthcare programs.
- Screen your directors, officers, employees and contractors initially and on a monthly basis against the Exclusion Lists to determine whether any of your employees/contractors have been excluded from participating in Medicare, Medicaid, State Children Health Insurance Program (SCHIP) or any federal healthcare programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. You must immediately report to Humana any exclusion information upon discovery. You must accept and acknowledge that civil monetary penalties may be imposed against providers who employ or enter contracts with excluded individuals or entities to provide items or services to members.
- Be screened, enrolled (including signing a SCHCC Medicaid provider participation agreement) and periodically revalidated in SCHCC's Medicaid Enterprise System (MES) Provider Services Solution (PRSS). This does not require you, as a Humana network provider, to render services to fee-for- service (FFS) beneficiaries.
- If you are only providing Medicare services to dual eligible integrated SNP members enrolled in the Humana Dual Integrated Plan Medicaid plan, you are not required to enroll in SCHCC.
- If you are an out-of-network provider, you are not required to apply and enroll as a provider in SCHCC. However, Humana registers all providers outside our network using the PRSS non-par provider registration (NPPR) file.
- Maintain records for 10 years from the date your provider contract terminates.
- Provide copies of member records and access to your premises to representatives of Humana, as well as duly authorized agents or representatives of SCHCC, the U.S. Department of Health and Human Services and the State Medicaid Fraud Unit. You must agree otherwise to preserve the full confidentiality of medical records in accordance with applicable state and federal laws.

- Maintain and provide a copy of the member's medical records, in accordance with 42 CFR §438.208(b)(5), to members and their authorized representatives as required by Humana and within no more than 10 business days of the member's request.
- Forward medical records to Humana within 10 business days of Humana's request.
- Submit utilization data for members enrolled with Humana in the format specified by Humana, consistent with Humana obligations to SCHCC, as related to quality improvement and other assurance programs as required.
- Promptly provide or arrange for the provision of all services required under the provider agreement. This provision must continue to be in effect for subcontract periods for which payment has been made even if you become insolvent until such time as the members are withdrawn from assignment to the provider.
- Should an audit by Humana or an authorized state or federal official result in disallowance of amounts previously paid to a provider, you must reimburse Humana upon demand. You shall not bill the member in these instances.
- Not bill a member for medically necessary services covered under the Medicaid Contract and provided during the member's period of Humana enrollment. This provision shall continue to be in effect even if Humana becomes insolvent. However, if a member agrees in advance of receiving the service and in writing to pay for a non-Medicaid covered service, then Humana, providers or Humana subcontractor can bill.
- Comply with federal contracting requirements described in 42 CFR Part 438.3, including identification of/nonpayment of provider preventable conditions, conflict of interest safeguards, inspection and audit of records requirements, physician incentive plans, recordkeeping requirements, etc.
- Report fraud, waste and abuse.
- Report critical incidents.
- Providers who bill for personal care and respite care services must commit to using an electronic visit verification system.
- Complete annual training which includes:
  - General Compliance (Ethics Every day and Compliance policy)
  - Fraud, waste and abuse
  - Medicaid provider orientation training
  - Cultural competency
  - Health, safety and welfare (abuse, neglect and exploitation)
  - Special needs training which covers the model of care

In addition to the responsibilities for all providers, PCPs are also responsible, to a minimum, for:

- Managing and coordinating the medical and behavioral healthcare needs of members to ensure 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.
- Maintaining a medical record of all services rendered by the PCP and a record of referrals to other providers and any documentation provided by the rendering provider to the PCP for follow-up and/or coordination of care.
- Developing a plan of care to address a patient's risks and medical needs.
- Working with Humana care coordinators to develop plans of care for members receiving care management services.
- Conducting screens to determine whether the member needs behavioral health services for common behavioral issues, including, but not limited to:
  - Depression
  - Anxiety
  - Trauma/adverse childhood experiences
  - Substance use
  - Early detection
  - Identification of developmental disorders/delays

HIDE-SNP Appendix Section 5: Covered services

Covered services

In this section, you will find a summary of the benefits and services covered by Humana's HIDE-SNP in South Carolina for our HIDE-SNP members. This is not a comprehensive list of all the services covered for HIDE-SNP members. For a comprehensive list of all services covered by Medicare, providers can check benefits at **Availity Essentials** (registration required) or call Humana Provider Services at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time. For a comprehensive list of Medicaid plan services, please review the **covered services chapter of the Medicaid portion of this manual**.

Please note that Humana offers 1 HIDE-SNP plan in South Carolina, available to members in all South Carolina counties:

- Humana Dual Integrated (HMO D-SNP)

Covered service	Limitations, exceptions and additional benefit information
Adult Day Health Services	Humana covers these services if a member is found to be eligible through the LTSS screening process. Prior authorization requirements may apply.
Ambulance services	Ambulance services for other cases (non-emergent) must be approved by Humana. In cases that are not emergencies, Humana may pay for an ambulance. The member's condition must be serious enough that other ways of getting to a place of care could risk their life or health. Prior authorization requirements may apply.
Ambulatory surgical center services	Prior authorization requirements may apply.
Care management services	Care management services are provided to all Humana HIDE-SNP members. Care management provides a more intensive level of service if the member's health requires it.
Chiropractic services	Humana covers only manual manipulation of the spine to correct subluxation. Other services performed by a chiropractor are not covered. Prior authorization requirements may apply.
Dental check-ups and preventive care	Humana provides a full range of dental care for both children and adults through DentaQuest, its Medicaid Dental Benefits Administrator. Contact 888-912-3456 for information or visit **Dentaquest.com**.

Covered service	Limitations, exceptions and additional benefit information
Diabetes supplies and services	For all people who have diabetes (insulin and non-insulin users). Prior authorization requirements may apply.
Diagnostic radiology services	Prior authorization requirements may apply.
Dialysis services	Certain drugs for dialysis are covered under a member's Medicare Part B drug benefit. Prior authorization requirements may apply.
Emergency room services	Members may use any emergency room if they reasonably believe they need emergency care. They do not need prior authorization, and the hospital does not have to be in-network. Members are covered for emergency care world-wide. If they have an emergency outside of the U.S. and its territories, they will be responsible to pay for the services rendered upfront.
Emergency transportation	In emergency situations, emergency transportation includes ground (ambulance) and air (airplane and helicopter) transportation. The transportation will take the members to the nearest place that can give them care.
Glasses or contact lenses	Coverage for eyeglasses is limited to members under the age of 21 except as a supplemental benefit.
Hearing screenings (including routine hearing exams)	Diagnostic hearing and balance evaluations performed to determine if the member needs medical treatment are covered as outpatient care when furnished by a physician, audiologist or other qualified provider. Prior authorization requirements may apply.
Home health services	Humana covers home health services, including nursing care, rehabilitation therapies and home aide services. Prior to receiving home health services, a provider must certify that the member needs home health services and will order home health services to be provided by a home health agency. The members must be homebound. HCBS services may require a prior authorization.
Home services such as cleaning or housekeeping or home modifications such as grab bars	Home modifications may be covered. Modifications may be made to the members' primary residence or primary vehicle and must enable them to function with greater independence. Prior authorization requirements may apply.
Inpatient and outpatient care and community-based services for people who need mental health services	Humana provides coverage for inpatient and outpatient mental health services including, but not limited to, crisis intervention and psychiatric hospitalization, case management, therapeutic and rehabilitative services, and residential treatment.

Covered service	Limitations, exceptions and additional benefit information
Inpatient hospital care	Prior authorization requirements may apply.
Lab tests and diagnostic procedures, such as blood work	Prior authorization requirements may apply.
Medical equipment for home care	Humana covers all medically necessary durable medical equipment (DME) covered by original Medicare. The most up-to-date list of suppliers is available on our website at **Humana.com/FindADoctor**. Prior authorization requirements may apply.
Medicare Part B prescription drugs	Part B drugs include drugs given in a provider's office, some oral cancer drugs and some drugs used with certain medical equipment.
Medicare Part D prescription drugs	There may be limitations on the types of drugs covered. How much members pay for a drug depends on whether they get the drug from: • A network retail pharmacy • A pharmacy that is not in Humana's network (we cover prescriptions filled at out-of-network pharmacies in limited situations only) • The plan's mail-order pharmacy
Mental health services	Humana provides coverage for a full range of inpatient and outpatient mental health services, including substance use disorder services. Certain telehealth mental health specialty services may be covered under physician/practitioner services.
Nursing home care	Provides coverage for nursing home care. Prior authorization requirements may apply.
Occupational, physical or speech therapy	Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices and Comprehensive Outpatient Rehabilitation Facilities (CORFs). Prior authorization requirements may apply.
Orthotics	Prior authorization requirements may apply.
Vision care	Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.
Outpatient hospital services, including observation	Unless the provider has written an order to admit the member as inpatient to the hospital, the member is outpatient. Even if the member stays in the hospital overnight, they might still be considered outpatient. Prior authorization requirements may apply.

Covered service	Limitations, exceptions and additional benefit information
Podiatry services	Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs Prior authorization requirements may apply.
Preventive care	There is no coinsurance, copayment or deductible for members eligible for Medicare-covered preventive services.
Prosthetic services	Humana provides coverage for medically necessary prosthetics for children under age 21, and for adults and children when recommended as part of an approved intensive rehabilitation program. Devices (other than dental) that replace all or part of a body part or function. Prior authorization requirements may apply.
Provider or surgeon care	Prior authorization requirements may apply.
Radiation therapy	Prior authorization requirements may apply.
Rehabilitation services	Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices and CORFs. Prior authorization requirements may apply.
Respite care	Humana covers respite care, including inpatient respite care, if a member is found to be eligible through the LTSS screening process.
Restorative and emergency dental care	Coverage for restorative and emergency dental care. Braces for adults over age 21 are not covered. Contact DentaQuest at 888-912-3456 for coverage information or visit **Dentaquest.com**.
Tobacco cessation	All medically necessary tobacco cessation services, including pharmacotherapy and counseling.
Skilled nursing care	Humana provides coverage for skilled and intermediate nursing facility care. Members are covered for up to 100 medically necessary days per benefit period. Prior hospital stay is not required. A new benefit period will begin on day 1 when the member first enrolls in an MA plan, or when they have been discharged from skilled care in a skilled nursing facility for 60 consecutive days. Prior authorization requirements may apply.
Specialist care	Prior authorization requirements may apply.
Substance use disorder services	Humana provides coverage for a full range of addiction treatment services, including outpatient and intensive outpatient services, case management, residential and opioid treatment services.
Transportation to medical appointments and services	Includes transportation to services covered by Medicare.

Covered service	Limitations, exceptions and additional benefit information
Urgent care	Urgently needed services are not emergency care. Members do not need prior authorization, and the urgent care center does not have to be in-network.
Visits to treat an injury or illness	Prior authorization requirements may apply.
"Welcome to Medicare" (preventive visit 1 time only)	Humana covers the Welcome to Medicare preventive visit only within the first 12 months the member has Medicare Part B.
Wellness visits, such as a physical	A member's first annual wellness visit can't take place within 12 months of their Welcome to Medicare preventive visit. However, they don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after they have had Part B for 12 months.
Wheelchairs, crutches, walkers, nebulizers, oxygen equipment and supplies	Humana provides coverage for wheelchairs, crutches and walkers, as well as a wide range of other DME items. DME coverage is based on medical necessity and has no maximum benefit limits. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can order it for you. The most recent list of suppliers is available on our website at **Humana.com/FindADoctor**. Prior authorization requirements may apply.

Value-added benefits and mandatory supplemental benefits

In addition to covered services, Humana Medicaid-enrolled members have access to value-added benefits, and Humana Medicare-enrolled members have access to mandatory supplemental benefits. HIDE-SNP members have access to both value-added benefits and mandatory supplemental benefits.

For a list of some of the value-added benefits and mandatory supplemental benefits offered to Humana HIDE-SNP members, please see the table below. Please note that this may not be an exhaustive list.

Benefit	Covered by	Description
Baby and me meals	Medicaid	Up to 2 pre-cooked home-delivered meals per day for 10 weeks for pregnant members who are high-risk.
Breast Pump	Medicaid	Pregnant and postpartum members can receive 1 non-hospital grade breast pump every 2 years.

Benefit	Covered by	Description
Convertible car seat and portable crib	Medicaid	Families actively participating in the HumanaBeginnings® program can receive one free car seat or one free portable crib after completing the prenatal comprehensive assessment. They may also receive one additional free item that was not previously received after completing the postpartum assessment and one follow-up call for each baby, per pregnancy. To request this benefit, please contact your Care Manager.
Healthy food produce box	Medicaid	Members living with or at risk of living with chronic conditions, Humana Healthy Horizons offers up to 4 produce boxes per year containing nutritious food that meets medical dietary guidelines, and educational materials that include recipes tailored to our member's condition. Members must have at least 1 of the following qualifying chronic conditions: • Congestive heart failure • Chronic obstructive pulmonary disease • Chronic kidney disease • End-stage renal disease • Cancer • Human immunodeficiency virus • Serious mental illness • Diabetes Type I • Diabetes Type II
Home-based asthma interventions	Medicaid	Members can receive up to $200 allowance per year for allergen free bedding, carpet cleaning and/or air purifier. Member must be asthmatic.

Benefit	Covered by	Description
Housing assistance	Medicaid	Members 18 and older can receive up to $500 per member per year to assist with the following housing expenses: • Apartment rent or mortgage payment (late payment notice required) • Utility payment for electric, water or gas (late payment notice required) • Trailer park and lot rent if this is a permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority Plan approval is required: • 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.
Housing support for SMI members	Medicaid	Members diagnosed with Serious Mental Illness and eligible for Intensive Case Management who are homeless, at imminent risk of becoming homeless, or transitioning from a behavioral health inpatient or residential facility without stable housing may be eligible for housing assistance up to $5,000. This once per lifetime assistance can cover rent/mortgage, security deposits, and utility deposits, household furnishings/supplies, and moving expenses. Benefits will be tailored to meet functional needs of each member. Members must meet the following criteria: • Diagnosed with Serious Mental Illness • Eligible for Intensive Case Management • 18 and older • Homeless (per U.S. Department of Housing and Urban Development (HUD) definition) or at imminent risk of becoming homeless (i.e. becoming evicted or losing current housing) • Must be able to continue paying for his/her expenses upon award of this one-time benefit Voluntarily consents to housing support allowance

Benefit	Covered by	Description
Newborn circumcision	Medicaid	Circumcision for all newborn male members from 29 days old through 12 months.
Non-medical transportation	Medicaid	Up to 15 round trips (30 one-way trips) up to 30 miles for non-medical transportation per year to locations such as social support groups, wellness classes, WIC and SNAP appointments, and food banks. This benefit also offers transportation to locations providing social benefits and community integration for members such as community and neighborhood centers, parks, recreation areas, and churches.
GED testing	Medicaid	GED test preparation assistance for members 16 and older is available, 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. This also includes a test pass guarantee to provide members multiple attempts at passing the test.
OTC pharmacy allowance	Medicaid	$65 per quarter allowance enables members to purchase products that support chronic condition management, medicines such as pain relivers, diaper rash cream, cough and cold relief medicine, and first aid equipment that do not require prescriptions.
OTC + Healthy Options Allowance	Medicare	$280 monthly allowance on a prepaid spending card. All plan members receive this amount to buy approved over the counter (OTC) health and wellness products at participating retailers or through the plan's approved OTC mail order vendor. Plus, members may also use this money for eligible groceries, utilities, rent, and more if they have certain qualifying chronic condition(s) and meet other program criteria. Any unused amount rolls over each month and expires at the end of the plan year or upon disenrollment, whichever occurs first.

Benefit	Covered by	Description
Medicare hearing benefit: Hearing aids (as well as fittings and associated accessories and supplies)	Medicare	**Medicare benefit:** Up to 2 TruHearing-branded prescription hearing aids every 3 years (1 per ear every 3 years). Benefit is limited to the TruHearing Advanced prescription hearing aids, which come in various styles and colors. Advanced hearing aids are available in rechargeable style options. Members must see a TruHearing provider to use this benefit. Members should call 844-255-7144 to schedule an appointment (for TTY, dial 711).
HMO Travel	Medicare	Covered services must be provided by providers within the national Medicare HMO or SNP network. If a member is planning to travel outside of their service area and anticipates needing to use the HMO Travel Benefit, it is recommended that they notify their PCP.
Tobacco & vaping cessation coaching	Medicaid	Tobacco & Vaping Cessation Coaching is focused on helping members aged 12 and older with stopping their usage of nicotine products. The program is designed as a monthly engagement for a total of 8 coaching calls, but the member has 12 months to complete the program if needed. • The program also offers support for both over the counter (OTC) and prescription nicotine replacement therapy (NRT) for members aged 18 and older.
Medicare meal benefit: Meal benefit	Medicare	**Medicare benefit**: Humana Well Dine® meal program. After a member's inpatient stay in either a hospital or a nursing facility, they may be eligible to receive 2 home delivered meals per day for 7 days (up to 14 meals). Meals must be requested within 30 day of discharge from their inpatient stay. Limited to 4 times per year.
Medicaid benefit: Post-discharge meals	Medicaid	**Medicaid benefit:** 14 pre-cooked, home-delivered meals that can be stored in the refrigerator following an inpatient or residential facility admission up to 4 times per year. **Note:** The Medicare benefit must be exhausted before the member can use the Medicaid benefit.
OTC pharmacy allowance	Medicaid	Up to $65 per quarter per household allowance enables members to purchase products that support appropriate care such as: • Feminine products • First aid equipment that does not require prescriptions.

Benefit	Covered by	Description
Self-monitoring devices-blood pressure monitoring kit	Medicaid	Members can receive a Digital Blood Pressure Kit, which includes a cuff and monitor, every 3 years. • Member is 21 and older • Prior authorization is required for members under 21 years old • The age limit and/or prior authorization does not apply to members who are pregnant or within 3 months postpartum
Weight management coaching	Medicaid	Weight Management Coaching helps members who are 12 and older achieve or maintain a healthy weight. Members can complete 6 sessions with a Wellness Coach; approximately 1 call per month for a period of 6 months.
Produce box for maternal care	Medicaid	Pregnant members that are between their second trimester to 60 days postpartum that are deemed food insecure can receive up to 4 boxes of in-season, nutritious, fresh food annually with Care Manager approval.
Restorative and emergency dental care	Medicare	A variety of dental services are covered in network at a $0 copayment until the maximum benefit coverage is reached annually. Frequency limits may apply. Note: The allowance cannot be used on fluoride, cosmetic services, and implants. • HMO D-SNP has a maximum benefit coverage amount of $1,500 The mandatory supplemental dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at **Humana.com/FindCare**.
SilverSneakers® fitness program	Medicare	Basic fitness center membership includes in-person and digital fitness classes.
Smartphone	Medicaid	With a smartphone, members have easy access to health-related information and can stay connected to their care team and health plan. Any member who qualifies for the Federal Lifeline program will be eligible to receive a free smartphone with monthly talk minutes, text and data.
Sports physical	Medicaid	1 sports physical per year is available for members 6 to 18 years of age.

Benefit	Covered by	Description
Vision	Medicare	$0 copayment for routine exam up to 1 per year. • $450 maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year Members 21 and older can receive an annual eye exam and an annual allowance of up to $150 to cover glasses frames and/or contact lenses.
Youth academic support	Medicaid	Empowering students to reach their full academic potential, this benefit offers personalized tutoring services for members between ages 5 - 18. With up to 20 hours of tutoring available over a 10-week period each year, students receive targeted assistance to enhance their learning experience and excel in their studies.
Youth development and recreation	Medicaid	• Members 18 and younger can receive reimbursement of up to $250 annually for participation in activities such as: • YMCA • Boys and Girls Club • Swim lessons • Computer coding classes • Music lessons

Go365 by Humana wellness program for HIDE-SNP members

Go365 by Humana® is a well-being and rewards program available to our HIDE-SNP members. Go365 rewards members for completing healthy activities, including getting preventive screenings, staying active and participating in community events. Rewards can be redeemed for gift cards in the Go365 Mall to help with everyday living expenses and other well-being related purchases. Members also have access to our libraries of expert-led online courses and podcasts on topics such as nutrition and cooking, heart health, diabetes management and on-demand fitness classes.*

Getting started

Members with a MyHumana account can use the same information to log in to **Go365.com**. If an account is not currently set up, they can activate their profile at **MyHumana.com**. Once logged in to

Go365, they'll see eligible activities they can complete to earn rewards, and details on how to track their actions.

Please view the chart below for a complete list of rewards:

Preventive activities	Reward value
Annual wellness visit	$25
Bone density screening	$20
Colorectal screening	$55
Diabetic bundle: (complete all 4 screenings for $40 reward) **Kidney urine test, kidney blood test, hemoglobin HbA1c test, diabetic eye exam**	$40
Flu vaccine	$5
Health Risk Assessment (HRA)	$10
Mammogram	$30
Medication usage survey	$10

Connect and Learn activities	Reward value
• Enroll and onboard for new members and returning members who register online for the first time. • Update and/or confirm email address in Go365 for existing members • Social and health education (attend a health education or art class, participate in an athletic event, social club or religious gathering or event)	$5 per activity per month, $10 annual maximum

Exercise and Fitness activities	Reward value
Complete a minimum of 12 workouts per month, tracked via SilverSneakers® fitness device, online or paper-based tracker (minimum of 5,000 steps/day). Other physical activities may include golfing, swimming, Zumba and yoga.	$5 for completing 12 workouts in a month, $60 annual maximum

* Available for members with SilverSneakers as part of their plan options

If members have questions about the Go365 program, they can call the number on the back of their Humana ID card. If a member disenrolls from a Humana HIDE SNP and enrolls with another MCO, their Go365 rewards will be forfeited. If a member leaves a Humana HIDE SNP and enrolls with a Humana Medicaid plan that includes Go365, they can call the number on the back of their Humana ID card within 90 days of their plan end date to redeem any remaining rewards.

Nonemergent transportation services

For members enrolled in either our HMO D-SNP nonemergency and routine medical transportation are covered. Depending on the specific transportation need, the HIDE-SNP the member is enrolled in, and their transportation benefit utilization history, members may access transportation through our Medicare transportation vendor, CareCar®, or our Medicaid transportation vendor, ModivCare®.

Members should call Humana Member Services at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time for transportation and benefit information and vendor coordination.

Behavioral health

For information on behavioral health, please refer to the **behavioral health chapter of the Medicaid portion of this manual**.

Family planning services

Methods of family planning, which include but are not limited to barrier methods, oral contraceptives, vaginal rings, contraceptive patches and long-acting reversible contraceptives, are covered for South Carolina HIDE-SNP members.

HIDE-SNP Appendix Section 6: Utilization management and utilization review

HIDE-SNP utilization management and utilization review program

Humana's utilization management and utilization review (UM/UR) program for HIDE-SNP members is managed by one department that is trained to understand both Medicaid and Medicare benefits covered for South Carolina HIDE-SNP members. The HIDE-SNP UM/UR department performs all UM/ UR activities for HIDE-SNP members, including prior authorization, concurrent review and discharge planning.

Prior authorizations

All HIDE-SNP-covered services that require prior authorization from Humana should be authorized before the service is delivered. To determine which HIDE-SNP-covered services require prior authorization, please review our Humana Dual Integrated Plan Preauthorization and Notification list at **Humana.com/PAL** under the Medicare tab or call 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time to request a copy. Please note that this PAL is specific to Humana's South Carolina HIDE-SNPs.

Requests for preauthorization should be made as soon as possible but at least 14 days in advance of the service date. It is important to request prior authorization as soon as you know that a Humana-covered patient requires a service on the Preauthorization and Notification List. The member, their PCP or their provider may initiate a request for services. Online requests are encouraged through **Availity Essentials**, our secure, payer-agnostic provider portal, but prior authorizations or notification requests can be requested through any of the following methods:

- Sign in to **Availity Essentials** (registration required). For select services, you can answer a series of questions when requesting the preauthorization. If approved, you will receive notification immediately. If you are pending further review, you can attach relevant clinical information to the request to expedite the process.
- Submit a business to business or batch Health Care Services Review and Response transaction (278) via EDI.
- Use our interactive voice response (IVR) system by calling 800-523-0023, Monday through Friday, 8 a.m. to 7 p.m., Eastern time. You should call this number if a request needs to be expedited due to the seriousness of a patient's condition.
- Fax requests to 866-652-8177.

When prior authorization is requested for a service rendered in the same month, HIDE-SNP member enrollment is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent on member eligibility on the date of service. You must verify enrollment on the date the service is to be rendered. Humana is not able to pay claims for services provided to ineligible members. For more information on prior authorizations for pharmacy services, please refer to the **Medicare pharmacy provider manual**.

Services that do not require prior authorization for HIDE-SNP members

Humana does not require prior authorization for the following services when provided to HIDE-SNP members:

- Any services for emergency medical conditions as defined in 42C.F.R §§ 422.113(b)(1) and 438.114(a) (which includes emergency behavioral health care)
- Urgent care sought outside of the service area
- Urgent care under unusual or extraordinary circumstances provided in the service area when the contracted medical provider is unavailable or inaccessible
- Vaccines and immunizations provided to members at local health departments

There may be additional services for which Humana does not require prior authorization, the above is not intended to be an exhaustive list.

Information required for a prior authorization request or notification

Information required for a prior authorization request or notification may include, but is not limited, to:

- Member's ID number and date of birth
- Relationship to subscriber
- Date of actual service or hospital admission
- Type of service
- Place of service
- Service quantity
- Procedure codes, up to a maximum of 10 per authorization request
- Date of proposed procedure, if applicable
- ICD Diagnosis codes (primary and secondary), up to a maximum of 6 per authorization request
- Service location
- Type of authorization—inpatient or outpatient
- TIN and NPI number of requesting provider
- TIN and NPI of treatment facility where service is being rendered

- TIN and NPI of the provider performing the service
- Name and telephone number of all providers indicated
- Attending physician's telephone number
- Relevant clinical information
- Discharge plans

Submitting all relevant clinical information at the time of the request will facilitate quicker determination.

Prior authorization request review process

If additional clinical or other information is needed to determine medical necessity, Humana will request the relevant information. When requesting necessary information, at least one attempt is completed, including via telephonic outreach and/or fax. The request will clearly indicate what additional information is required to complete the prior authorization request. Humana may request additional clinical information to complete the medical necessity review, when needed, but will not request documentation that would change the authorized services or hours.

Notification of prior authorization decisions

When submitting a service authorization request for a service that is covered by both Medicare and Medicaid, Humana first adjudicates the request by using our Medicare medical necessity criteria. If any service is not approved under Medicare for the amount, duration, or frequency requested, Humana will review to determine if the service can be approved by Medicaid using the Medicaid medical necessity criteria. After adjudicating the request using both the Medicare and Medicaid medical necessity criteria, we notify the requesting provider of the decision. For any adverse benefit determinations, Humana sends the member a written notice, called a Coverage Decision Letter, on an integrated organization determination within the applicable standard or expedited time frames outlined below.

- **Standard time frame:** For standard prior authorization decisions, Humana provides a decision as expeditiously as the member's health condition requires, but no later than 7 calendar days following authorization request date. The time frame for a standard authorization request may be extended up to 14 calendar days if you or the member requests an extension, or if Humana justifies, in writing, to SCHCC a need for additional information and how the extension is in the member's best interest. Written notice of the extension will be provided to the member and will include the reason for the extension and the member's right to file grievance.
- **Expedited time frame:** For cases in which you indicate, or Humana 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 will complete an expedited authorization decision within 72 hours and provide notice as expeditiously as the member's health condition requires. If a request needs to be expedited due to the seriousness of a patient's condition, please call 800-523-0023, Monday through Friday, 8 a.m. to 7 p.m., Eastern Time.

Referrals

Similarly to Medicaid members, if a HIDE-SNP member requires specialized treatment beyond the scope of a PCP, the member may see an in-network specialist for consultation and/or treatment without a referral from their PCP. However, if a member requires medical services from a nonparticipating provider, you need to request a referral. You can view the status of your referral requests by visiting **Availity Essentials**. The status of a referral can be verified by accessing **Availity Essentials** or by calling 800-523-0023, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

The PCP initiates the referral by submitting a referral request through Availity Essentials. Methods for submitting referral requests are outlined in the preauthorization section above and on **Humana.com/PAL**. The PCP receives a referral number from Humana if the referral request is completed, and Humana determines whether the services are covered under the provider agreement; provided by an approved provider/facility; and medically necessary. An approved referral number does not override member eligibility, provider agreement exclusions, etc. Prior to the specialist rendering services, preauthorization also must be obtained by the specialist for any additional medications or services on the preauthorization and notification list.

After the member has been treated by a specialist, the specialist's findings, diagnosis and recommendation for treatment should be sent to the member's PCP. The specialist also must submit claim/encounter data to Humana.

Facility closure or license termination

In the event Humana is notified of a facility closure or license termination, we will collaborate with the Office of the Long-term Care Ombudsman, Department for Aging and Rehabilitation, the local Department of Social Services and other state agencies to ensure all member transfer and discharge rights are upheld.

Retrospective review

A retrospective review is a request for a review for authorization of care, a service or a benefit for which an authorization is required but not obtained before the delivery of care, service or benefit. On request, Humana only allows for a retrospective authorization submission after the date of service when a prior authorization is required but not obtained. When submitting a retroactive authorization request, please include the following documentation:

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

When retrospective review is required, providers must include clinical information to perform a medical necessity review.

A retrospective review request for inpatient and outpatient services for HIDE-SNP members can be submitted via Availity Essentials or by contacting **Availity Essentials** directly at 800-282-4548, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

For requests submitted via Availity Essentials or by fax, you can check the status online at **Availity Essentials**. You can see the authorization status along with the authorization number associated with the request. Some outpatient authorization requests may auto-approve if the procedure code is not listed on our online Humana Dual Integrated Plan Preauthorization and Notification list at **Humana.com/PAL**.

Humana notifies the requesting provider and provides written notice of all determinations that deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested. For adverse benefit determinations, Humana will notify the member by letter with a copy to you at the address on file. Written notification for approved service requests is not provided unless requested.

Medical necessity criteria and reviews

All decisions to approve or deny services for HIDE-SNP members are based on eligibility, coverage and medical necessity criteria. Humana 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 establishes measures designed to maintain quality of services and control costs consistent with our responsibility to our members. Humana places appropriate limits on a service based on criteria applied under the Medicaid state plan and applicable regulations, such as medical necessity.

The fact that a provider has prescribed, recommended or approved medical or allied care, goods or services does not make such care, goods or services medically necessary or a medical necessity or a covered service. Humana 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 (LTSS) are authorized in a manner that reflects the member's ongoing need for such services and support.

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 will be determined when the claim is received for processing.

Humana 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 LTSS are authorized in a manner that reflects the members' ongoing need for such services and support.

You can request the clinical rationale or criteria used in making UM determinations for a HIDE-SNP member through the same methods as you would for a Medicaid member.

Out-of-network services

On notification of authorization from a referring provider, Humana will arrange out-of-network care if we are unable to provide necessary covered services or ensure the second opinion of an in-network provider. Humana may authorize other out-of-network services to promote access to services and continuity of care.

Transition of care

The members are supported by the interdisciplinary care team (ICT) through transitions of care (TOC) between care settings (e.g., hospital to home). Humana is required to offer/provide care coordination to all members. The HRA is completed upon enrollment and a member-centric, individual plan of care is developed with an ICT which includes pharmacists, dieticians, social services, etc., depending on the member's needs. The member is supported by the ICT through TOC between care settings (e.g., inpatient discharge).

Discharge planning

The hospital's UM and discharge planning departments and the patient's attending physician/PCP are responsible for establishing the discharge plan. The Humana team is available to assist with complex discharge planning, when needed. Hospitals should provide Humana with discharge dates and discharge plans of Humana discharged members each day to assist with post-discharge follow up, coordination of care and referrals to other clinical programs that may be available to the member.

Peer-to-peer

Prior to an adverse determination is communicated, the practitioner may be given an opportunity to discuss the services being requested for the member and the clinical basis for treatment with a medical director or other appropriate reviewer. For HIDE-SNP plans, the discussion must be completed prior to rendering adverse determination.

Once an adverse determination has been made, participating providers are given the opportunity to submit a provider dispute. A participating provider may submit a dispute prior to submitting a claim or appeal under the following circumstances.

- Humana's adverse determination was based on lack of medical necessity for an authorization request that was retrospective (retro) or concurrent to the service
- A peer-to-peer conversation with a Humana Medical Director was not held prior to the adverse determination

Physicians/providers have 5 calendar days from the date on the notification letter or until the member has been discharged, whichever is later, to request the pre-claim dispute.

For more information on how a provider can submit an appeal please refer to the **Member and Provider Grievances, Appeals and Reconsiderations section of this manual**.

Second medical opinions

A member has the right to a second medical opinion in any instance in which the member questions the reasonableness, necessity or lack of necessity for the following:

- Surgical procedures
- Treatment for a serious injury or illness

- Other situations in which the member feels that he/she is not responding to the current treatment plan in a satisfactory manner
- HIDE-SNP members can obtain a second opinion from another participating physician, but the PCP may require a referral. The final treatment plan is determined by the member's PCP.

Follow-up services must be obtained through or arranged by the member's PCP.

Clinical review guidelines

For HIDE-SNP plans, Humana applies Medicare coverage guidelines, including national coverage determinations (NCDs), and local coverage determinations (LCDs), program manuals and transmittals. When CMS does not have highly established coverage criteria, Humana has created Humana Medical Coverage policies based on evidence-based authoritative literature and nationally accepted clinical guidelines, such as Milliman Care Guidelines® (MCG) to interpret or supplement the general CMS provisions to properly apply Medicare reasonable and necessary criteria.

In these instances, Humana uses nationally accepted clinical guidelines, such as MCG guidelines to help consistently interpret the medical necessity of services. MCG is a set of industry leading evidence-based care guidelines. MCG uses peer-reviewed papers and research studies each year to develop and update the care guidelines in strict accordance with the principles of evidence-based medicine. The review guidelines may be used as a screening guide to approve services during the utilization management process. Humana's Medicare coverage policies, MCG care guidelines and ASAM guidelines are available to practitioners and members at **Humana.com**. Any clinical criteria used in making UM determinations are available upon request by contacting our Utilization Management department. Send written requests to:

Humana Correspondence:

P.O. Box 14054

Lexington, KY 40512-4054

Submit by fax: 877-889-9934

Submit by phone: 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time

Prior to an adverse medical necessity determination, a licensed, board-certified medical director reviews all available clinical documentation to evaluate if guidelines are met. The medical director renders a decision in accordance with clinical review guidelines and currently accepted medical standards of care, considering the individual circumstances of each case.

Adverse determination

If a member or member's provider disagrees with a utilization review decision, the member, the member's authorized representative or the provider may request reconsideration.

HIDE-SNP Appendix Section 7: Care management

Overview of care management for HIDE-SNP members

HIDE-SNP members are assigned to one care manager who coordinates and integrates all their care, including services and support covered by both Medicaid and Medicare. This streamlines the member's experience with care management compared to having 2 separate care coordinators for Medicaid and Medicare. Humana HIDE-SNP members have access to the same care management programs and care managers as Humana Medicaid members. All HIDE-SNP members are assigned to a care manager. HIDE-SNP members may be identified as one of 2 priority population groups for assignment to care management: Mandatory High Priority, and Mandatory Low Priority.
For information about referring members to care management, accessing member care plans, completing member health screenings, and participating in interdisciplinary care teams, please refer to the **care management chapter of the Medicaid portion of this manual**.

Model of care approach

As provided under section 1859(f)(7) of the Social Security Act, every SNP, including HIDE-SNPs, must have a model of care (MOC) approved by the NCQA. The MOC provides the basic framework under which each SNP will meet patient needs. It serves as the foundation for promoting SNP quality, care management and care coordination processes.

Humana's MOC has 4 goals:

- To improve member outcomes by coordinating care and ensuring care transitions
- To improve member access to and utilization of services and benefits
- To increase members' satisfaction with their healthcare experience and health status
- To ensure cost-effective service delivery

Humana achieves these goals by:

- Conducting HRAs to identify risk needs
- Developing a plan of care to address identified needs
- Providing access to an interdisciplinary care team

Humana's HIDE-SNP MOC includes, but is not limited to, the following elements:

- Providing the full scope of care coordination services for all members by stratifying them into an initial care management level of service
- Conducting health risk assessments such as post discharge emergency department or inpatient assessment to identify the member's needs
- Review all available historical information, including information from other Medicare payer sources, claims data, and external records such as care plans and referrals
- Evaluate and ensure members are placed within the most appropriate risk level and ensure they are receiving care coordination to meet their needs
- Provide access to quality healthcare and support to all members based on an individualized assessment of care needs
- Monitor for changes in condition or needs that warrant adjustment in the member's care coordination level of service
- Include processes and systems of care that engage members and family members in person-centered care management and culturally competent care
- Ensure seamless transactions between levels of care and care settings, addressing all barriers to accessing appropriate services to support member health

All contracted providers serving SNP members must review and attest to our SNP Training for Physicians, which includes information on our MOC. To learn how to access the training and obtain additional information about the model, please refer to **Humana.com/ProviderCompliance**. For more information on our South Carolina HIDE-SNP model of care, please review the **care management chapter of the Medicaid portion of this manual**.

HIDE-SNP Appendix Section 8: Quality management and improvement

HIDE-SNP Quality Assessment and Performance Improvement Program overview

CMS, NCQA, URAC, Accreditation Association for Ambulatory Health Care (AAAHC) accreditation programs, and SCHCC require that Humana oversees a Quality Assessment and Performance Improvement (QAPI) program inclusive of Medicare, Medicaid, LTSS, dual eligible and SNP lines of business and products. The purpose of our QAPI program is to continually monitor, evaluate and improve the healthcare services our members receive as well as the processes, procedures and performance results generated by clinical and other business areas that support quality of clinical care, safety of clinical care, quality of service and member experience. Humana's QAPI program is a comprehensive quality improvement program that encompasses clinical care, preventive care, population health management and our administrative functions. It is designed to monitor and evaluate—objectively and systematically—the quality, appropriateness, accessibility and availability of safe and equitable medical and behavioral healthcare and services. We identify strategies and implement activities in response to findings. Using a continuous quality improvement methodology, our QAPI program works to:

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

QAPI program activities, which are included in the QAPI workplan and its annual evaluation, include monitoring clinical indicators or outcomes, quality-of-care complaints, utilization metrics, quality studies, HEDIS measures, CAHPS results and medical record audits. Humana's board of directors delegates a QAPI committee to monitor and evaluate the results of program initiatives and to implement corrective action when the results are less than desired or when areas that need improvement are identified. The QAPI Committee is accountable to Humana's executive management team.

The QAPI program goals include:

- Developing clinical strategies and providing clinical programs that look at the whole person while integrating behavioral and physical healthcare
- Identifying and resolving issues related to member access and availability of healthcare services
- Ensuring participating providers and other stakeholders are involved in the QAPI program
- Providing effective customer service for members and provider needs and requests
- Monitoring coordination and integration of member care across provider sites
- Providing a comprehensive strategy for population health management that addresses member needs across the continuum of care
- Providing mechanisms to assess the quality and appropriateness of care furnished to members with special healthcare needs
- Providing mechanisms to detect underutilization and overutilization
- Monitoring and promoting the safety of clinical care and service
- Promoting better communication between departments to improve service and satisfaction with members, practitioners, providers and associates
- Promoting improved clinician experience for providers and all clinicians to promote member safety, provider satisfaction and provider retention

QAPI program activities include:

- Developing clinical practice guidelines
- Performing medical record documentation reviews
- Analyzing HEDIS report results
- Assessing member satisfaction
- Requesting external quality reviews

Information regarding the QAPI program is available on request. To receive a written copy of Humana's quality program and its progress toward goals, providers can call Provider Services at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

Quality measures

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

- **Quality improvement projects** – Ongoing measurements and interventions
  - Significant quality of care improvement and service delivery in both clinical care and non-clinical areas are expected to 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 can be requested when investigating complaints of poor quality or service or clinical outcomes. You must furnish member medical records to Humana 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 ensure all HIPAA guidelines are enforced.

- **Performance measures** – Data collected on patient outcomes as defined by HEDIS or otherwise defined by SCHCC
- **Surveys** – CAHPS, provider satisfaction, behavioral health surveys and special surveys implemented to support quality/performance improvement initiatives
- **Peer review** – Review of providers' practice methods and patterns to determine appropriateness of care

Humana uses the measures above to help measure Medicare patients' experiences with their health plans and the entire healthcare system, which CMS uses a 5-star quality rating system to measure. Humana's goal is to support physicians by identifying care opportunities that will improve the health outcomes and care experience of your patients.

Provider participation in the QAPI Program

You are required to cooperate with Humana's quality improvement activities. You must participate in and contribute required data to Humana's quality improvement and other assurance programs, which includes providing member records for assessing quality of care and External Quality Review Organization (EQRO) activities. In addition, the 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 PHI to health plans without member authorization for treatment, payment and healthcare operations activities. Healthcare operations include, but are not limited to, conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs, care management and care coordination. You also must allow Humana to use your provider performance data as part of quality improvement activities.

Behavioral health providers must collect clinical outcomes data and make available behavioral health clinical assessment, treatment planning and outcomes data for quality, utilization and network management purposes.

Participating providers serving HIDE-SNP members must agree to allow and assist Humana with our performance of the following quality investigations activities:

- **Quality-of-care occurrences and adverse events reporting:** Quality-of-care occurrences and adverse events may also be reported by Risk Management and Humana clinical associates. Cases are reviewed and, as applicable, referred to the peer-review process, as required by law and accrediting agencies.
- **CMS Quality Improvement Organization (QIO):** QIO oversees the Medicare Advantage Prescription Drug (MAPD) plans and collaborates with the plans for quality improvement activities.
- **Member grievances:** Oral and written member grievances pertaining to quality of care may be referred to by the Quality-of-Care Investigations team for review.

You shall participate in Humana's quality review program as requested. Humana routinely reviews the quality of its providers, investigates concerns as they arise and may request additional information and/or remediation from you. You must agree to comply with Humana's requests for information and any remediation plan.

Humana encourages providers to participate in CMS and Health and Human Services QI initiatives, the Chronic Care Improvement Program, and Humana's quality improvement initiatives.

Medical record requirements

As a network provider, you must make medical records for each member available to SCHCC, the contracted EQRO and other SCHCC designees upon request.

You must provide copies of member records and access to your premises to representatives of Humana, as well as duly authorized agents or representatives of SCHCC, the U.S. Department of Health & Human Services, and the state Medicaid Fraud Unit. Humana provider representatives must have access to the provider's office records and operations. This access allows Humana to monitor compliance with regulatory requirements. Each provider office must maintain complete and accurate medical records for all Humana-covered patients receiving medical services in a format and for time periods as required by the following:

- Applicable state and federal laws
- Licensing, accreditation and reimbursement rules and regulations to which Humana is subject
- Accepted medical practices and standards
- Humana's policies and procedures

Your medical records must be available for utilization, risk management, peer review studies, customer service inquiries, grievances and appeals processing, claims disputes, quality investigations of potential quality-of-care concerns, compliance audits and other initiatives Humana might be required to conduct. To comply with accreditation and regulatory requirements, Humana may periodically perform a documentation audit of some provider medical records. You must meet 85% of the requirements for medical record keeping with a goal of 90%, or per applicable state and federal requirements if more stringent.

You must respond to the Humana member grievance and appeal unit expeditiously with submission of required medical records to comply with time frames established by CMS and/or the state department of insurance for processing grievances and appeals. Only those records for the period designated on the request should be sent. A copy of the request letter should be submitted with a copy of the record. The submission should include test results, office notes, referrals, telephone logs and consultation reports. Medical records should not be faxed to Humana unless the provider can ensure confidentiality of those medical records.

For HMO plans, if a Humana-covered patient changes their PCP for any reason, the provider must transfer a copy of the patient's medical record to the patient's new PCP at the request of the plan or patient. The agreement states whether the original or a copy of the medical record must be sent.

If a provider terminates, the provider is responsible for transferring the patients' medical records. Charges for copying medical records are considered a part of office overhead and are to be provided at no cost to Humana-covered patients and Humana, unless state regulations or the agreement stipulate otherwise.

Providers can submit relevant medical records to Humana several ways, including but not limited to:

- Humana's Medical Records Management application on Availity Essentials at **www.availity.com**
- Fax to 866-305-6655
- Mail to: Humana Medical Records Management

  P.O. Box 14465
  Lexington, KY 40512-4465

You must preserve the full confidentiality of medical records in accordance with your provider agreement. To be compliant with HIPAA, you should make reasonable efforts to restrict access and limit routine disclosure of PHI to the minimum necessary to accomplish the intended purpose of the disclosure of patient information. You must forward medical records to Humana within 10 business days of Humana's request. Additionally, you must maintain and provide a copy of the member's medical records, in accordance with 42 CFR §438.208(b)(5), to members and their authorized representatives within no more than 10 business days of the member's request.

All member medical records must include the required elements pursuant to 42 CFR §§ 456.111 and 456.211, including but not limited to:

- **Member ID in the record:** Records should include the patient's name, date of birth, sex/gender identification, race, phone number, place of residence and responsible party (parent or guardian as applicable). In records where each element isn't present, use your clinical judgment to determine completeness by majority.
- **Primary language:** Use of the patient's primary language should be documented along with any need for communication assistance provided.
- **Complete medical history:** Medical history should be easily identifiable and include serious accidents, operations, illnesses and familial/hereditary disease. It should include medical history, diagnoses, treatment prescribed, therapy prescribed, and drugs administered or dispensed. For pediatric patients, past medical history includes prenatal care and birth information and childhood illnesses (members aged 11 years and younger). In records where each element isn't present, use your clinical judgment to determine completeness by majority.
- **Allergies:** 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.
- **After hours/hospital follow-up (if noted that member had these services):** Record should show documentation of emergency department and/or after-hours encounters, hospital reports including admission and discharge summaries and referrals/results outcomes.
- **Diagnostic testing:** Record should show documentation of lab, X-ray, imaging or other studies ordered. Results should be filed in the medical record and initiated by the primary care physician, thereby signifying review. Abnormal X-ray, lab and imaging study results should have an explicit

notation in the medical record regarding follow-up plans and notification to patient of all results (positive and negative). In records where each element isn't present, use your clinical judgment to determine completeness by majority.

- All written denials of service and the reason for the denial
- **Immunization record:** A current record of immunizations should appear in the patient chart.
- **Advance directives:** For members aged 18 and older, there should be evidence that the patient has been asked if they have an advance directive (written directions about healthcare decisions) and a "yes" or "no" response should be documented. If the response is "yes", a copy of the advance directive must be included in the medical record.
- **Preventive screenings:** There is evidence that preventive screenings are offered or referred (e.g., EPSDT, BCS, CCS, eye exam) and results/status of screenings addressed from previous visits are documented/addressed
- Each visit must include:
  - Date of service
  - Location of service
  - Purpose of visit (or chief complaint)
  - Diagnosis of medical impressions
- **Physical exam (complete):** All body systems should be reviewed within 1 year of the first clinical encounter or all body systems must be reviewed upon first visit, including HEENT (head, eyes, ears, nose and throat), teeth, neck, heart, lungs, neurological and musculoskeletal. In records where each element isn't present, use your clinical judgment to determine completeness by majority.
- **Vital signs:** Height, weight, blood pressure and temperature must be documented.
- Assessment of patient's findings
- Plan of treatment, diagnostic tests, therapies and other prescribed regimes
- Medications prescribed (All current medications, including dose and date of initial prescription or refills, should be present in the medical record) long-term medication reviewed and reconciled.
- Health education provided
- Name, 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 which signature is represented by which initial)

If your contract with Humana terminates, you must maintain records for 10 years from the date your provider contract terminates.

Clinical practice guidelines

Patient safety is addressed through adherence to clinical guidelines that target preventable conditions.

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 implements activities to identify interventions, the support and activities of families, friends, providers and the community have a significant impact on prevention.

Humana disseminates and monitors the use of clinical practice guidelines relevant to members that:

- Are based on valid and reliable clinical evidence or a consensus of healthcare professionals or in the relevant field
- Consider the needs of managed care members
- Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines including professional medical associations, voluntary health organizations and National Institutes of Health centers
- Are congruent with current NCQA standards for establishing guidelines
- Do not contradict existing South Carolina-promulgated regulations or requirements as published by the Departments of Social Services, Health, Health Professions, Behavioral Health and Developmental Services, South Carolina Department of Health or other state agencies
- Prior to adoption, have been reviewed by Humana's medical director, as well as other contractor practitioners and network providers, as appropriate
- Are reviewed and updated, as appropriate or at least every 2 years
- Are reviewed and revised, as appropriate, based on changes in national guidelines or changes in valid and reliable clinical evidence or consensus of healthcare professionals and providers

We strongly encourage you to review and consider these guidelines. You ultimately remain responsible for determining the applicable treatment for every individual. Clinical and practice guidelines are distributed to all new and existing providers through the following formats:

- Provider manual updates
- Provider newsletters
- Provider website

Humana's clinical practice guidelines are available on our website at Clinical Practice Guidelines for Healthcare Providers at **https://provider.humana.com/patient-care/guidelines**. You also can obtain preventive health and clinical practice guidelines through your Provider Relations representative. Humana notifies you whenever changes are made.

Quality management reviews for HCBS waivers and programs

For information on quality management reviews for HCBS waivers and programs, please refer to the **quality management chapter of the Medicaid portion of this manual**.

HIDE-SNP Appendix Section 9: Pharmacy

Pharmacy overview

Humana HIDE-SNP members have access to an integrated formulary that includes both their Medicaid and Medicare pharmacy benefits. Information on our formularies and pharmacy processes can be found in the **Medicare pharmacy provider manual**. The manual includes information on the following:

- How to join our network
- Contact information
- Eligibility verification
- Drug coverage
- Claims procedures
- Controlled substances
- Medicare claims coverage
- Long-term care
- Home infusion billing procedures
- Compound claims
- Medication Therapy Management (MTM) program
- Pharmacy audit and compliance
- Complaint system
- Price source and maximum allowable cost information
- Code editing and payment policies

Requesting coverage determinations

You can request coverage determinations, such as medication prior authorization, step therapy, quantity limits and formulary exceptions, by:

- Obtaining forms at **Humana.com/PA**
- Submitting requests electronically by visiting **Covermymeds**
- Faxing requests to 877-486-2621

- Calling Humana Clinical Pharmacy Review (HCPR) at 800-555-CLIN (800-555-2546), Monday through Friday, 8 a.m. to 8 p.m., Eastern time.

The coverage determination decision will be reviewed based upon medical necessity and our decision communicated within the applicable timeframe after the request is received from the prescriber.

To find out which services require authorization, please review the prior authorization and notification lists at **Humana.com/PAL**.

Pharmacy and Therapeutics Committee

Humana and other health plans in the state are required to follow the Common Core Formulary and utilization management. For drugs in Common Core Formulary open drug classes, Humana reviews changes through Humana's Pharmacy and Therapeutics (P&T) Committee. Humana's P&T Committee ensures safe, appropriate and cost-effective use of pharmaceuticals for Humana members. The P&T Committee serves in an evaluative, educational and advisory capacity to Humana staff and participating providers in matters including, but not limited to, pharmacy requirements and the appropriate use of medications. Humana P&T Committee meets at least quarterly and is comprised of physicians and pharmacists holding valid professional licenses. The committee includes at least 1 practitioner in each of the following specialties: pediatrics, gerontology/geriatrics and psychiatry. All individuals participating in the P&T Committee must complete a financial disclosure form annually, which is reviewable upon request.

Coverage limitations

Humana limits coverage to a standard supply of medication per prescription per enrollee in accordance with the prescriber's orders and applicable regulations. Humana generally allows processing of a 30-day supply, and in some cases up to a 100- day supply with certain exclusions. Specific day supply limits may vary. Providers should refer to the plan's formulary and applicable coverage benefits for guidance on drug supply limits and exceptions.

Prescription drug formulary

In accordance with 42 CFR § 438.10(i), Humana makes the following information available about our formulary in electronic or paper form:

- Which medications are covered (both generic and name brand); and
- What tier each medication is on

Humana formulary drug lists are available on the **Humana website** at **https://www.humana.com/pharmacy/medicare-drug-list**.

Humana allows access to all medically necessary nonformulary or nonpreferred drugs, other than those excluded from coverage.

If Humana administers a closed formulary, there is an exception process for circumstances where the formulary does not adequately accommodate a member's clinical needs and a process for prescribing practitioners to submit information that supports exception requests.

Formulary updates

Humana may add or remove drugs from the formulary throughout the year. Humana may also change utilization management requirements for covered drugs.

Notification of negative changes to the formulary and utilization management requirements are provided to all affected participating providers and members prior to the effective date of the change. Providers can view changes and the current preferred drug list at **Humana.com/PAL** as well as the current **medical and pharmacy coverage policies** at **https://mcp.humana.com/tad/tad_new/home.aspx?type=provider**.

Medications administered in the provider setting

Humana covers medications administered in a provider setting, such as a physician office, hospital outpatient department, clinic, dialysis center or infusion center. Utilization management requirements exist for many injectables. Humana may add or remove drugs from the PAL throughout the year. Providers can view those changes and the current PAL at **Humana.com/PAL**.

Medication Therapy Management program

Humana offers an MTM program that helps ensure members achieve the best possible outcomes from their medications. The patient-centered MTM program promotes collaboration between the pharmacist, enrollee and prescriber to optimize safe and effective medication use. The goal of this program is to optimize therapeutic outcomes by focusing on safety, effectiveness, lower-cost alternatives and adherence. Prescribers with questions about the program can call Humana Clinical Programs at 833-349-4114, Monday through Friday, 9 a.m. to 5:30 p.m., Eastern Time.

HIDE-SNP Appendix Section 10: Claims and billing

HIDE-SNP claim submission and status

All HIDE-SNP member claims are submitted to 1 integrated claims address, removing the requirement for you to identify what should be submitted to Medicare vs. what should be submitted to Medicaid. You can submit claims, both initial and corrected, as well as check status of claim submission for HIDE-SNP members via **Availity Essentials**. Please review the claims and billing chapter of the HIDE-SNP portion of this manual. for more information on submitting electronic and paper claims, as well as:

- Tips for avoiding common claims submission errors
- NPI and TIN
- Clean claims
- Submitting claims for hysterectomies, sterilizations, abortions, immunizations and vaccinations
- Provider preventable conditions and services
- Timely filing requirements (Humana's timely filing requirement for all providers, including in-network and out-of-network providers, is 365 days from the date of service, and 180 days from the date of explanation of payment for corrected claims)

HIDE-SNP claim processing

When you submit a claim for a HIDE-SNP member, the claim is first reviewed for Medicare coverage, then for Medicaid coverage. You do not have to bill both Medicare and Medicaid when you submit a claim for a HIDE-SNP member, unless the member is receiving Medicaid services via fee-for-service Medicaid. In this scenario, you would need to submit a claim to Humana first and then submit the EOR you receive from Humana to SCHHS (or another MCO if applicable).

HIDE-SNP claim payment

When you submit a claim for a HIDE-SNP member, regardless of if the claim is adjudicated and paid by Medicaid only, Medicare only, or both Medicare and Medicaid, you will receive one EOR and one payment. Your EOR will explain payments made by Medicaid and Medicare, as applicable. For information on signing up to receive electronic payments and electronic remittance advice, as well as overpayments and suspension of provider payments, please review the claims and billing chapter of the HIDE-SNP portion of this manual.

Cost sharing protections

You are prohibited from imposing cost-sharing requirements on Humana HIDE-SNP members that would exceed the amounts permitted under the South Carolina State Plan for Medical Assistance. Except for patient pay liability amounts for LTSS services as established by the local DSS, you must consider Humana's payment as payment in full and must not bill or balance bill any Humana HIDE-SNP members for covered services provided during the member's period of Humana enrollment.

HIDE-SNP Appendix Section 11: Provider reconsiderations, appeals and complaints

Provider reconsiderations and complaints

Provider reconsideration process:

If providers disagree with Humana's initial adjudication of a claim, they can request a reconsideration of the issue. This includes disagreements regarding Humana's payment, denial, and nonpayment of the claim, which includes Humana's denial of a claim due to a denied authorization request. Providers may submit a reconsideration via the following methods:

- Online:
  - Sign in at **www.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.
- Mail:
  - Use the address on the back of the patient's Humana ID card or mail to:
    Humana Correspondence

    P.O. Box 14359

    Lexington, KY 40512-4359

When submitting a request for reconsideration in writing, providers should include all the following information:

- Provider name
- Provider NPI and Tax ID
- Member name and ID number
- Date of service
- Relationship of the subscriber to the patient
- Claim number
- Charge amount
- Payment amount

- Proposed correct payment amount
- Difference between the amount paid and the proposed correct payment amount
- Brief description of the basis for the contestation request
- Relevant supporting documentation (e.g., medical records, copy of invoice, referral form)
- Reconsiderations for participating providers must be received by Humana within 18 months of the date the claim was paid, or within 6 month for nonparticipating providers—unless state or federal law or the agreement requires another time—or the claim will not be reconsidered.

See the providers section of **Humana.com** for claims payment policies and further information about claims disputes.

If the provider is unsatisfied with the outcome of Humana's review of a claim denial resulting from a denied authorization request, the provider can submit a second dispute following the same process outlined above.

Escalated review process

If the provider is unsatisfied with the outcome of the claims dispute review process, except for claim denials resulting from a denied authorization request, the provider can submit a request for an additional review to **HumanaProviderServices@humana.com**.

The Provider Concierge Unit reviews escalated issues when providers are unable to obtain resolutions to disputes via normal submission methods. Providers will need to include the same information that was submitted with the initial dispute along with any reference ID number provided during previous contact with Humana. The provider will receive an immediate auto-acknowledgement email advising that communication was received. Within 72 hours, the provider will receive an email with a reference ID number that can be used when corresponding with the Provider Concierge Unit.

Note: The above provisions of this section are to be considered as separate and distinct from the reconsideration provisions set forth in the provider agreement.

HIDE-SNP Appendix Section 12: Member grievances, appeals and State Fair Hearings

Filing grievances and appeals

Humana has an integrated grievance and appeal process for our South Carolina HIDE-SNP members. Members can file a grievance or appeal verbally by calling Humana Member Services at 866-432-0001, Monday through Friday, 8 a.m. to 8 p.m., Eastern time. To file a grievance or appeal in writing, the member may send a letter to:

Humana

Grievances and Appeals

P.O. Box 14546

Lexington, KY 40512-4546

The grievance or appeal request should include:

- Member's name, address, telephone number and Humana ID number
- Facts and details regarding the issue and the requested outcome
- The member's signature and date

Members can contact Member Services to request assistance by filing a grievance or appeal. Humana is also available to help throughout the grievance and appeal process, if needed. We identify and remove any communication barriers that can impede members or representatives from filing grievances and appeals. We facilitate the request to file or respond to an appeal for a member who has a communication challenge affecting their ability to communicate or read through the following means:

- The TTY line is available for the hearing impaired.
- A translation service is used to facilitate a cultural or linguistic request for members who are unable to speak or read English.
- Extra accommodation is arranged for any member with special needs who is unable to follow the standard process.

Member grievances

Members and their authorized representatives have the right to file a grievance at any time if they are dissatisfied with any matter other than an adverse action or adverse benefit determination.

An authorized representative must have the member's written consent to file a grievance. Humana acknowledges the receipt of each grievance within 5 business days of receipt.

Possible subjects for grievances include, but are not limited to:

- The quality of care or services provided
- Aspects of interpersonal relationships such as the rudeness of a provider or employee
- Failure to respect the members' rights

Humana resolves standard grievances and provides notice as quickly as the member's health condition requires, but no later than 30 calendar days from the date of receipt. Humana will expedite the grievance processing and provide a resolution within 24 hours if the grievance is regarding any of the following:

- Humana's decision to extend the resolution timeframe for an integrated organization determination (an organization determination for an applicable integrated plan) or for an integrated appeal (an appeal for an applicable integrated plan)
- Humana's denial of a request to expedite an integrated organization determination or an integrated appeal

The time frame for resolving a grievance can be extended by 14 calendar days if the member or their authorized representative requests an extension, or if Humana justifies the need for an extension and the extension is in the best interest of the member. If Humana extends the time frame for a grievance not at the request of the member, Humana will make reasonable efforts to give the member prompt oral notice of the delay. Humana will also send written notice of the decision to extend the time frame within 2 calendar days and inform the member of the right to file a grievance if they disagree with that decision.

Member appeals to Humana

A member, the member's attorney, or the member's authorized representative (e.g., provider, family member) acting on behalf of the member can file an appeal request, either orally or in writing. Humana cannot process a grievance or appeal from a member's authorized representative without an executed Appointment of Representative form. A provider also can file an appeal on behalf of the member when the request is not a request for expedited payment. Appeal requests must be received within 60 calendar days after receipt of the adverse organization determination, unless the appellant can demonstrate good cause. The date of receipt of the adverse organization determination is presumed to be 5 calendar days after the date of the integrated organization determination notice. If the appeal is received after the allowed timeframe, the request will be reviewed to determine whether a good cause circumstance exists that prevented the appeal from being filed in a timely manner. Good cause should be provided in writing and state why the request was not filed on time.

Humana resolves standard appeals and provides notice as quickly as the member's health condition requires, but no later than 30 calendar days from the date of receipt. Humana acknowledges the receipt of each appeal within 5 business days.

Humana has an expedited review process for integrated appeals when it is determined (with respect to a request from the member) or a provider indicates (when making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain or regain maximum function. Expedited appeals are resolved as quickly as the member's health condition requires, but no later than 72 hours after Humana receives the request.

In instances where the member's request for an expedited appeal is denied, the appeal is decided according to the time frame for standard resolution and the member is given prompt oral notice of the decision. Additionally, within 2 calendar days, the member is sent a written notice of the reason for the decision to deny the request for an expedited appeal and is informed of the right to file a grievance if the member disagrees with that decision.

Punitive action will not be taken against a provider who requests an expedited resolution or supports a member's integrated appeal.

Humana may extend the time frame for expedited or standard appeals by up to 14 calendar days if the member or their authorized representative requests the extension, or if Humana justifies the need for additional documentation and the delay is in the member's best interest. For any extension not requested by the member, Humana will make reasonable efforts to give the member prompt oral notice of the delay and written notice within 2 calendar days of the reason for the decision to extend the time frame. The members will also be informed of the right to file a grievance if they disagree with the decision to extend the time frame.

Next level appeals

Humana provides an integrated appeal decision notice. If the result of the appeal is for Humana to uphold, in whole or in part, its adverse benefit determination involving Medicare, the issues that remain in dispute are reviewed and resolved by an Independent Review Entity (IRE), which is an independent, outside entity that contracts with CMS. The IRE will review the appeal decision, decide whether it is correct and issue a written determination. If the IRE reverses Humana's decision to deny, limit, or delay services that were not furnished while the appeal was pending, we will authorize the service under dispute within 72 hours from the date Humana receives notice of the IRE decision, or we will provide the service under dispute as expeditiously as the member's health condition requires, but no later than 14 calendar days from that date. Furthermore, we will effectuate a payment reversal by the IRE within 30 calendar days.

If Humana upholds, in whole or in part, its adverse benefit determination involving Medicaid, the member or their authorized representative may request a State Fair Hearing within 120 calendar days of the date on Humana's notice of appeal resolution.

The appeal decision letter will provide the reason(s) for the adverse determination and explain the next level of the Medicare and/or Medicaid appeal process. The next available appeal rights vary depending on whether the service or item being requested is covered under Medicare, Medicaid, or if there is overlapping coverage. The appeal decision is binding on all parties unless it is appealed to the next applicable level. If the member pursues the appeal in multiple forums and receives conflicting

decisions, Humana is bound by, and will act in accordance with, the decision that is most favorable to the member.

Continuation of benefits

A member or their authorized representative can request continuation of services that are being reduced or terminated during the appeal and State Fair Hearing process if the following conditions are met:

- The member files the appeal or State Fair Hearing request timely,
- The appeal involves the termination, suspension or reduction of previously authorized services,
- The services were ordered by an authorized provider,
- The period covered by the original authorization has not yet expired, and
- The member files the request for continuation of benefits timely.

Continuation of services must be requested within 10 calendar days from the date on the appeal decision letter, or before the date Humana said services would be reduced, suspended, or terminated, whichever is later.

If the member receives a continuation or reinstatement of their benefits while the appeal or State Fair Hearing is pending, Humana will continue the benefits until one of the following occurs:

- The member or authorized representative withdraws the appeal or State Fair Hearing request.
- A State Fair Hearing officer issues a decision that is adverse to the member.

If the final resolution of the State Fair Hearing upholds Humana's action and services to the member were continued while the appeal or State Fair Hearing was pending, Humana may recover the cost of the continued services from the member, in accordance with SCHCC's policies on recovery.