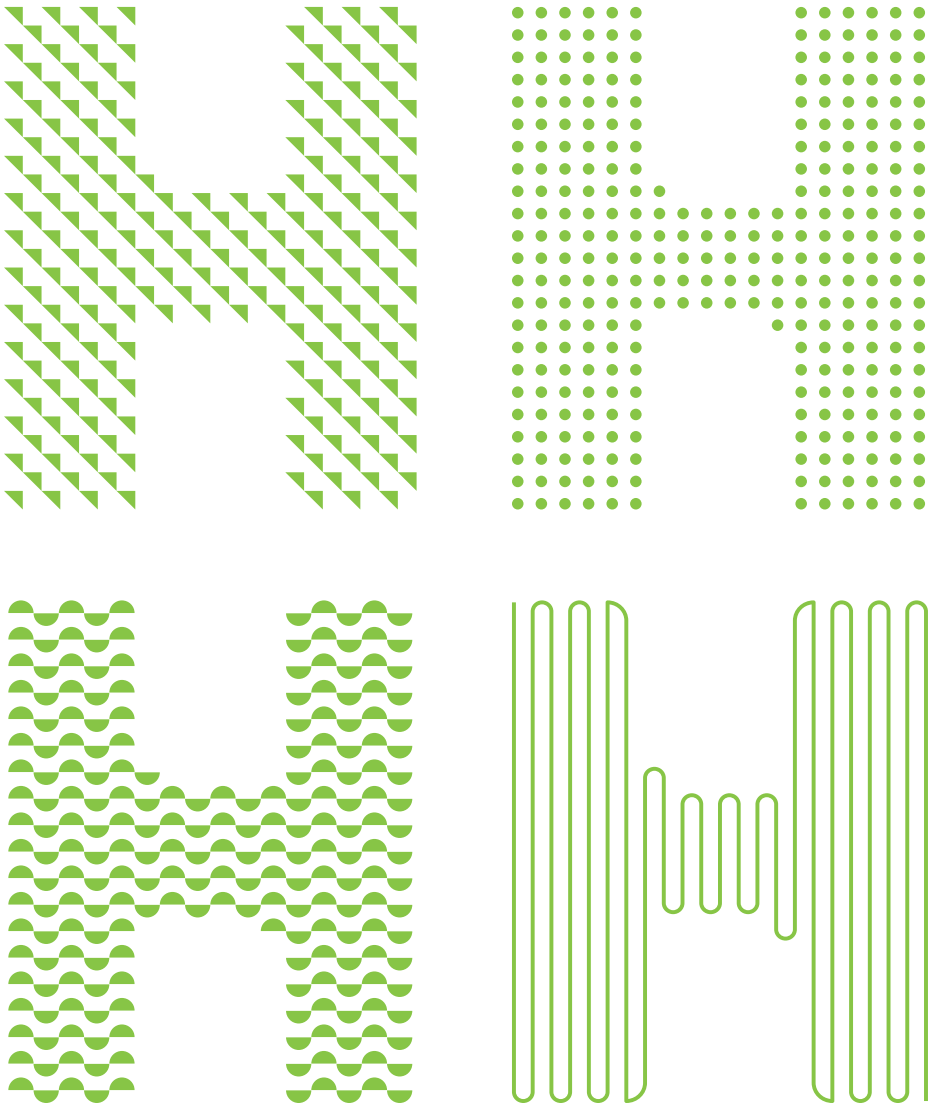

2024 Provider Manual

HUMANA HEALTHY HORIZONS IN OKLAHOMA

Humana Healthy Horizons in Oklahoma | SoonerSelect

Humana Healthy Horizons in Oklahoma is a Medicaid product of Humana Wisconsin Health Organization Insurance Corporation

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Chapter 1: Introduction

Welcome

Thank you for becoming a participating provider with Humana Healthy Horizons® in Oklahoma. This plan is for members with Oklahoma SoonerSelect Medicaid benefits administered through the Oklahoma Health Care Authority (OHCA). We strive to make doing business with Humana as easy as possible, facilitating high-quality care and a positive experience for both members and providers. We have a robust support structure for our provider network to deliver a best-in-class experience that is operationally efficient and ensures high-quality care. Humana Healthy Horizons is led by a local president, chief executive officer and leadership team, as well as locally dedicated provider services staff and member-facing teams that include care managers. To build a strong relationship between Humana Healthy Horizons and its contracted providers, your assigned Provider Relations representative will serve as your primary point of contact to facilitate communication.

For more than 60 years, Humana has helped members improve and maintain their health through clinical excellence and coordinated care. Our successful history in care delivery and health plan administration helps us create a new kind of integrated care with the power to improve health and well-being, and lower costs.

We are committed to building strong relationships with providers that foster member well-being. Our range of clinical capabilities, combined with our member programs and resources, produce a simplified experience that makes healthcare easier to navigate and more effective for our members.

Compliance and ethics

Humana Healthy Horizons and our provider network are responsible for complying with applicable state and federal regulations, along with applicable Humana policies and procedures.

Humana Healthy Horizons is committed to conducting business in a legal and ethical manner. Humana established a compliance plan that achieves the following:

- Formalizes Humana's commitment to honest communication within the company and within the community, inclusive of our providers, members and employees
- Develops and maintains a culture that promotes integrity and ethical behavior
- Facilitates compliance with all applicable local, state, and federal laws and regulations
- Implements a system for early detection and noncompliance reporting with laws and regulations; fraud, waste and abuse concerns; or noncompliance with Humana policy, and 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 outlines general compliance and ethics expectations for our providers:

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

For questions about ethical and compliance expectations, please contact your Provider Relations representative or call the Provider Services Contact Center at **855-223-9868 (TTY: 711)**, Monday through Friday, 8 a.m. to 5 p.m., Central time.

Accreditation

Humana holds a strong commitment to quality. We demonstrate our commitment through programs based on national standards, when applicable. Humana pursues accreditation from the National Committee for Quality Assurance (NCQA) for our Medicaid line of business in Oklahoma.

Accessing benefits provided by the state of Oklahoma

You can obtain information about benefits provided by the state by visiting https://oklahoma.gov/ohca.html.

Provider portal

Humana partnered with Availity Essentials™ to allow providers to reference member and claim data for multiple payers using one login. Availity Essentials provides the following benefits:

- Check eligibility and benefits
- Access certificate of coverage
- Submit preauthorization and referral requests
- Check status of preauthorization and referral requests
- Access to plan of care
- Access to member summary
- Respond to medical record requests
- Check claim status
- Check claim submission
- Submit of disputes and appeals
- Check remittance advice
- Manage overpayments
- Request electronic remittance advice/electronic funds transfer (ERA/EFT) enrollment
- Access provider directory
- Access to Humana-specific applications, resources and news

To learn more, call Availity at **800-282-4548** or visit **Availity.com**.

Communicating with Humana

Contact name	Contact information
Member/Provider Services Contact Center	**855-223-9868 (TTY: 711)**, Monday – Friday, 8 a.m. – 5 p.m., Central time
Member 24-hour nurse advice line (24/7/365)	**800-854-6619**
Provider Relations	**OKMedicaidProviderRelations@humana.com**
Prior authorization (PA) assistance for medical procedures and behavioral health	**855-223-9868** **www.humana.com/healthyOK**
PA for pharmacy	**800-555-2546**
Medicaid care management	**855-223-9868** **OKMCDCaseManagement@humana.com**
Fraud, waste and abuse	• Special Investigations Unit (SIU) Hotline: **800-614-4126** (24/7 access) • Ethics help line: **877-5-THE-KEY** (877-584-3539) • Mail to: Fraud, waste and abuse Humana 1100 Employers Blvd. Green Bay, WI 54344
Tribal concierge unit	**855-223-9868**
Provider complaints	**OKMedicaidProviderRelations@Humana.com**
Member grievance and appeals	Member grievance and appeals Humana P.O. Box 14546 Lexington, KY 40512-4546
Claims	Claims Humana P.O. Box 14359 Lexington, KY 40512-4359
Overpayments	Humana Healthcare Plans P.O. Box 931655 Atlanta, GA 31193-1655

Communicating with the Oklahoma Health Care Authority

OHCA Call Center:
405-522-6205 or **800-522-0114**

OHCA provider education specialist:
SoonerCareEducation@okhca.org

OHCA administrative office:
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105
405-522-7300
OHCA website: **oklahoma.gov/OHCA**

Member fraud:
Oklahoma Department of Human Services (OKDHS) Fraud Hotline – State of Oklahoma
800-784-5887 – Oklahoma City Hotline

Provider fraud:
Office of Attorney General – Medicaid Fraud Control Unit
313 NE 21st Street
Oklahoma City, OK 73105
405-521-3921 – Oklahoma City
918-581-2885 – Tulsa

Medicaid Fraud Control Unit | Oklahoma Attorney General
U.S. Department of Health and Human Services Office of Inspector General:
National: **800-447-8477** – National Hotline TTY: **800-377-4950**
U.S. Department of Health and Human Services
Attn: Hotline
P.O. Box 23489
Washington, DC 20026

Chapter 2: Member enrollment and eligibility

Medicaid eligibility

Eligibility is determined by OHCA. OHCA provides eligibility information to Humana Healthy Horizons for members assigned to Humana. Eligibility begins on the first day of each calendar month except for deemed newborns.

Newborn enrollment

Humana Healthy Horizons begins coverage of newborns on the date of birth when the newborn's mother is a member of a Humana Healthy Horizons. The delivery hospital is required to enter the birth record into the birth record system, Oklahoma's Certificate of Live Birth, Hearing, Immunization and Lab Data. That information is used to auto-enroll the newborn deemed eligible within 24 hours of birth. You can verify eligibility for a newborn through Availity Essentials at **Availity.com**.

Automatic renewal

If Humana Healthy Horizons members lose Medicaid eligibility but become eligible again within 60 days, they are automatically reenrolled and assigned to the same primary care provider (PCP), if possible.

New member kits

Each new member receives an ID card and a new member kit with a welcome letter. New member kits are mailed separately from the ID card.

New member kits contain:

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

Automatic PCP assignment

The PCP serves as the member's initial and most important point of interaction with Humana Healthy Horizons' provider network. A PCP is an individual physician, nurse practitioner, physician assistant, Indian Health Coverage Program (IHCP) or federally qualified health center (FQHC)/rural health clinic (RHC) 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 illness treatment and may treat the member directly, refer the member to a specialist (secondary/tertiary care) or admit the member to a hospital. Members have freedom of choice among participating providers.

All Humana members choose or are assigned to a PCP on enrollment in the plan. PCPs help facilitate a "medical home" for members. This means PCPs help coordinate healthcare for the member and provide additional health options to the member for self-care or care from community partners. PCPs are also required to know how to screen and refer members for behavioral health conditions. Members select a PCP from our provider directory.

A PCP is assigned to members if one is listed on the supplemental enrollment file. If a PCP is not on the file, members have 30 days to choose a PCP. If a member does not choose a PCP within 30 days of enrollment, a PCP is automatically assigned to the member. Humana Healthy Horizons' internal system can identify a member's previous PCP (if applicable) within Humana's participating PCP panel and assist through auto-assignment. Geographic assignment is used when a member has no record of past PCP relationships within the participating Humana PCP panel. Humana Healthy Horizons' internal editing system also ensures that the auto-assigned PCP is age-appropriate for the member (i.e., pediatricians are assigned to pediatric members and adults are assigned to PCPs who specialize in the treatment of adults).

PCP changes

Members have the option to change to another participating PCP as often as needed. Members initiate the change by calling the Member Services Contact Center. PCP changes are effective on the first day of the month following the requested change.

Referrals for release due to ethical reasons

Humana does not deny coverage for services or benefits because of moral or religious objections. You are not required to perform treatments or procedures that are contrary to your conscience, religious beliefs, or ethical principles, in accordance with 42 C.F.R 438.102.

In this case, you should refer the member to another provider who is licensed, certified, or accredited to provide care for the member's medical condition. The provider must be enrolled with OHCA and participating with Humana to provide Medicaid services to beneficiaries. In such circumstance, where your conscience, religious beliefs, or ethical principles require involuntary dismissal of the member as your patient, your office must notify the member of the dismissal by certified letter.

The letter should include:

- Reason for the release request
- Referral to another provider licensed, certified or accredited to provide care for the member's medical condition
- Instructions to contact Humana Healthy Horizons Member/Provider Contact Center at **855-223-9868 (TTY: 711)** for assistance in finding a preferred in-network provider.

A copy of the letter must be mailed or faxed to Humana at the following address:

Humana Provider Relations
Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax: 800-949-2961

Please call the Humana Member/Provider Contact Center at **855-223-9868 (TTY: 711)** if you have questions about the member release reasons or procedures.

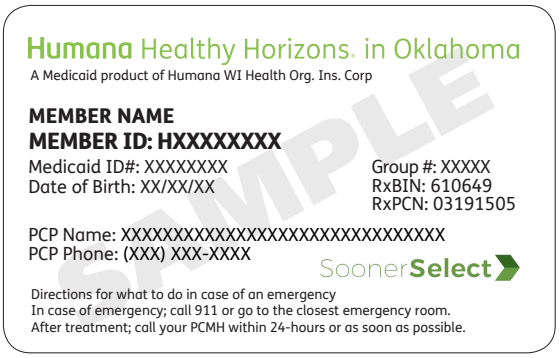
Member ID cards

All new Humana Healthy Horizons members receive a Humana Healthy Horizons member ID card. After the issuance of the initial card, a new card is issued only when the card information changes, when a member loses a card or when 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 disenroll from Humana Healthy Horizons and retain their ID cards. Likewise, members may lose Medicaid eligibility at any time. Therefore, it is important that providers verify member eligibility prior to every service.

Information included on the ID card includes:

- Member name
- Member's date of birth
- Humana Member ID number – Use this number on claims.
- Medicaid ID number – Please do not use this number to bill Humana.
- PCP/clinic name assigned to the member
- Member services – Phone number and TTY
- 24-hour nurse line – Phone number members can call to reach a registered nurse 24 hours a day, 365 days a year
- Behavioral health services hotline – Members can call **888-445-8742** 24 hours a day, 365 days a year for behavioral health support and triage, including mental health and substance use services.
- Availity Essentials – Availity Essentials contains plan information and access to special functionality, including as eligibility verification, claim and prior authorization submission, coordination of benefits (COB) check and more.
- Medical claims address:
  Humana Claims Office
  P.O. Box 14359
  Lexington, KY 40512-4359
- Pharmacy – Call the Member/Provider Services Contact Center if you have questions about pharmacy benefits and services.

Card front



Card back

Except in emergencies, providers must verify member eligibility and request healthcare insurance information before rendering services. Providers can verify member eligibility and obtain information for other healthcare insurance coverage on file by accessing Availity Essentials at Availity.com.

Member disenrollment

Members can be disenrolled from Humana for several reasons, including loss of Medicaid eligibility. If members lose Medicaid eligibility, they lose eligibility for Humana Healthy Horizons benefits. The state may notify Humana Healthy Horizons a member has lost eligibility retroactively. This occurs occasionally and, in those situations, Humana Healthy Horizons recoups payments made for dates of service when a member was not eligible. The recoupment code appears on the next remittance advice for impacted claims.

Member disenrollment also can be initiated for the following reasons:

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

Please notify Humana Healthy Horizons Provider Services by calling **855-223-9868 (TTY: 711)**, if any of the previously listed situations occur.

Ending enrollment with Humana Healthy Horizons

Members are permitted to change contracted entities (CE) without showing cause during the first 90 days of their enrollment with Humana Healthy Horizons or during the 90 days following the date OHCA sends the member notice of that enrollment, whichever is later. Members also are permitted to change CEs without cause at least once every 12 months during the open enrollment period. After the member's period for disenrollment from the contractor lapses, members remain enrolled with the CE until the next annual open enrollment period, unless:

- The member is disenrolled due to loss of SoonerCare eligibility
- The member becomes a foster child under custody of the state
- The member becomes juvenile justice-involved under the custody of the state
- The member is a former foster care child or is a child receiving adoption assistance and opts to enroll in the SoonerSelect Children's Specialty Program
- The member demonstrates cause in accordance with Section 1.6.7.2 "Member Request"
- The member's temporary loss of eligibility or enrollment causes the member to miss the annual disenrollment period; in those instances, the member may disenroll without cause or reenrollment
- The member's CE is sanctioned by OHCA, and the intermediate sanctions imposed on the CE allows a member to disenroll without cause

Chapter 3: Member support services and benefits

Member services

Humana Member Services Contact Center can assist members who have questions or concerns about services, such as care management, disease management, nonemergency transportation coordination and benefits.

Representatives are available by calling **855-223-9868 (TTY: 711)**, except on observed holidays. If the holiday falls on a Saturday, Humana is closed the Friday before. If the holiday falls on a Sunday, Humana is closed the Monday after. Members can access information such as claims history, eligibility, benefits and Humana Healthy Horizons' preferred drug list (PDL) 24 hours a day at their MyHumana account. Providers can access claims and authorization history and check a member's eligibility and benefits through Availity Essentials at **Availity.com**.

Nonemergency medical transportation

Humana Healthy Horizons offers unlimited transportation for all provider appointments, dialysis, X-rays, lab work or other medical appointments. Transportation also is covered for medical appointments if the member is bedridden or paralyzed. Providers must obtain prior authorization from Humana Healthy Horizons for nonemergency ambulance use. Humana Healthy Horizons also offers members 21 and older two round trips per calendar year for non-medical purposes.

How to obtain nonemergency transportation

If a member needs access to a car, wheelchair van, stretcher services or nonmedical transportation, providers can call ModivCare at **877-718-4213**. To cancel a ride, please call at least 24 hours in advance.

Interpreter services

If you are assisting a Humana Healthy Horizons member that needs interpretive services, please be aware Humana Healthy Horizons provides the following communication services at no cost when the member interacts with us. You can connect Humana Healthy Horizons members to these services through one of the following:

- Over-the-phone interpretation available in 150 languages by calling the Member/Provider Services Contact Center
- American Sign Language interpreters (in person or via video) — call **877-320-2233** to schedule
- Linguistically trained interpreters for visually impaired customers—call **877-320-2233** to schedule
- Teletype (TTY) services — This is voice-to-text provided by the federal relay service

Written materials available in languages other than English, and in alternative formats including Braille, audio, large print, and accessible PDF, can be requested by the provider or the member by calling the Member/Provider Services Contact Center at **855-223-9868**.

Health education

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

Member 24-hour nurse advice line

Members can ask an experienced staff of registered nurses about health-related symptoms 24 hours a day, 365 days a year, by calling **800-854-6619**. The nurses educate members about the benefits of preventive care and make referrals to our disease- and case-management programs. They also promote the PCP-member relationship by explaining the importance of the PCP in coordinating the member's care.

Key features of this service include:

- Assessment of member symptoms
- Professional advice regarding the appropriate level of care
- Helpful answers to health-related questions and concerns
- Referral information about other services
- Encouragement of the PCP-member relationship

The nurses assess member symptoms using evidence-based triage protocols and decision support.

Behavioral health services hotline for emergency crisis services

For members experiencing a behavioral health crisis in Oklahoma, Humana Healthy Horizons contracted with Solari to provide a behavioral health crisis hotline available to Humana Healthy Horizons' members 24 hours a day, 365 days a year. This voluntary service is designed to provide crisis intervention and connect members to the appropriate level of treatment within the community to prevent unnecessary hospitalizations or institutional levels of care. Once a member is directed to the most appropriate intervention, Humana Healthy Horizons works with providers to authorize services and ensure continuity of care for the member.

Behavioral health conditions include, but are not limited to:

- Those that create emotional distress
- 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

The behavioral health services hotline can be reached by calling **888-445-8742**.

Family planning

Members, including adolescents, may receive family planning services and related supplies from appropriate Medicaid family planning providers regardless of participating or nonparticipating network status. Members may self-refer to nonparticipating providers. Family planning services do not require prior authorization. These services include:

- Comprehensive medical history and physical exam, including anticipatory guidance and education related to the member's reproductive health/needs and contraceptive counseling
- Laboratory tests for the detection of certain sexually transmitted infections, cancerous or precancerous conditions, and determination of pregnancy
- Annual supply of chosen contraceptive
- Insertion and removal of contraceptive devices
- Sterilization procedures including vasectomy and tubal ligations; payment is not made for sterilization procedures for members younger than 21
- Additional visits for member experiencing difficulty with their contraceptive method or with concerns with their reproductive health

Chapter 4: Care management and care coordination

Humana Healthy Horizons' care management (CM) program is a holistic and fully integrated health management program. We provide comprehensive and integrated services starting with the initial member assessment across the continuum of care, focused on both acute and chronic condition management within behavioral health and physical health. Our CM approach supports and enhances providers' care and treatment. Our multidisciplinary team (MDT) collaborates with providers to ensure the best and most comprehensive care for members. This collaborative approach can support patient health and well-being by:

- Reducing admission and readmission risks
- Managing anticipatory transitions
- Engaging noncompliant members
- Reinforcing medical instructions
- Assessing social determinants of health (SDOH)

Our personalized approach includes an MDT with:

- Medical and behavioral health nurses
- Social workers and other licensed behavioral health professionals
- Outreach specialists:
  - Community health workers
  - Housing specialists
  - SDOH coordinators

We place the member at the center of the care management process by:

- Helping the member identify personal health goals and priorities
- Supporting the member in reaching those goals
- Educating the member in how to self-manage chronic and infectious diseases
- Establishing interventions to manage chronic disease and reduce associated risks
- Providing guidance to support healthy living and compliance with plans of care
- Stressing the importance of identifying early and ongoing barriers to care
- Partnering with the member and/or caregiver to enhance medical appointment compliance

To refer members needing CM assistance, call **855-223-9868,** email **OKMCDCaseManagement@humana.com** or fax **877-473-0056**.

Humana Healthy Horizons adheres to a no-wrong-door approach to CM referrals. Humana Healthy Horizons assists with provider referrals, appointment scheduling, and an integrated approach to the member's health and well-being by coordinating care between behavioral health providers, PCPs and specialists. Behavioral health providers are required to send initial and quarterly summary reports to the member's PCP and to refer members to PCPs for untreated physical health concerns.

Referrals

Humana Healthy Horizons offers individualized member education and support for many conditions and needs, including assistance with housing and accessing community support.

Direct access for member CM referrals and needs assistance is available 8 a.m. to 5 p.m., Monday through Friday, Central time by calling **855-223-9868**, faxing **877-473-0056** or emailing **OKMCDCaseManagement@humana.com**.

We encourage and invite providers to take an active role in their patients' CM programs, participate in the development of a comprehensive care plan and become part of an MDT. Member plans of care and health needs assessments are viewable on Availity Essentials and are available on request by calling our CM team at **855-223-9868**. We encourage you to refer members who might need individual attention to help them manage special healthcare challenges.

Care management risk levels

After agreeing to enroll in the CM program, members are assessed using Humana Healthy Horizons' comprehensive assessment protocol to evaluate physical, behavioral and psychosocial factors, including SDOH and environmental identifiers, which may contribute to chronic diseases. Once members are assessed, the care manager stratifies the member based on multiple factors, including condition complexity, utilization and clinical judgement, into the following

CM risks levels:

Low-risk members
These members typically demonstrate rising risk and need focused attention to support their clinical care needs and address SDOH. Conditions require a moderate amount of coordination of care, given the complexity of member physical, behavioral or social needs. Care plans are developed based on individual needs and include treatment plans as appropriate.

Medium-risk members
These members typically demonstrate rising risk and need focused attention to support their clinical care needs and address SDOH. Conditions require a moderate amount of coordination of care, given the complexity of member physical, behavioral or social needs. Care plans are developed based on individual needs and include treatment plans as appropriate.

High-risk members
Members with high-risk and complex conditions require the most focused attention to support their clinical care needs and address SDOH. Members involved in this level of CM receive weekly contacts to review plans of care and quarterly reassessment for changing needs. Case managers focus on implementing the member's plan of care, preventing institutionalization and other adverse outcomes, and supporting the member in self-managing their care goals.

High-risk/complex members
Members engaged in complex CM are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. These members have multiple or complex conditions (behavioral or physical health) that require intensive management and coordination, or have significant barriers to self-management, including SDOH that might lead to unplanned hospitalization.

Wellness and prevention
Humana Healthy Horizons supports members in wellness so as to maintain an optimal level of health. Wellness and prevention programs are available to all active Humana Healthy Horizons members and include incentives for vaccinations, well visits, healthy lifestyle education and more, push notifications and/or educational mailings.

Transitional care management

Humana Healthy Horizons coordinates services it provides to the member between settings of care regardless of the member's behavioral or physical health diagnosis, including appropriate discharge planning for short- and long-term hospital and institutional stays. Transition planning is a core CM activity, supporting the member between institutional and community care settings including, but not limited to, transitions to/from inpatient hospitals, nursing facilities, psychiatric facilities, psychiatric residential treatment facilities, therapeutic group homes, permanent supportive housing, intermediate care facilities, residential substance use disorder (SUD) settings and transitions out of incarceration.

Care managers focus on implementing the member's plan of care, preventing institutionalization and other adverse outcomes, and supporting the member in self-managing their care goals. Specifically, transitional CM also includes:

- Support for members as they transition from inpatient care to the community
- Follow-up appointment support
- Delivery of at-home and/or post-discharge items
- Review of discharge instructions and medication changes

Chronic condition management program

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

- Improve member understanding and assist self-management of a member's disease with education and support while following a provider's plan of care
- Help members maintain optimal health 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 member use of access to care, including home healthcare services

- Find and obtain community-based resources to meet the member's medical, psychological and social needs
- Develop routine reporting and feedback loops for progress notes via phone or secure fax, which may include communications with members, providers, health plans 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, evaluation, instruction, intervention and documentation of goals and outcomes for members with the following conditions/diagnoses:

- Opioid and other SUDs
- Tobacco cessation
- Childhood obesity
- Behavioral health issues
- Diabetes
- Cardiovascular disease
- Prenatal care and postpartum outcomes
- Children receiving private duty nursing (PDN) services
- Children receiving out-of-home placement services
- Access to preventive health services
- Member health literacy

Neonatal intensive care unit care management program

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 Heathy Horizons NICU CM program are registered nurses who help families understand the treatment premature babies receive while they are in the hospital and prepare to care for the infants at home. They 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 the Provider Services Contact Center at **855-223-9868**.

Transplant care management program

Our transplant care management program serves as a single point of contact for members who require an organ transplant, a stem cell transplant, placement of a ventricular assist device, total artificial health, or immune effector cell therapy, including chimeric antigen receptor T cell therapy. We provide benefit guidance (including travel and lodging, if eligible) before and after the procedure, as well as education and guidance on comparing National Transplant Network facilities. The transplant CM program also reviews all requests for transplants and issues authorizations as appropriate.

HumanaBeginnings maternity program

All pregnant members are eligible to join our maternity CM program, HumanaBeginnings®. Members are eligible to receive CM services tailored to their acuity level. The maternity CM program assists high-risk members with support for the development of and adherence to treatment plans, resources and support for substance use or mental health concerns, and referrals to community-based programs and resources. HumanaBeginnings coordinates referrals to community resources and programs, including Women, Infant, and Children (WIC), Supplemental Nutrition Assistance Program (SNAP) and Supplemental Nutrition Assistance Program Nutrition Education (SNAP ED).

Care management participation

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 Availity Essentials and are available on request by contacting our CM team. If you would like to contact our care management team or have a Humana Healthy Horizons member with chronic conditions you believe would benefit from this program, please call Provider Services at **855-223-9868** or email **OKMCDCaseManagement@humana.com**.

Chapter 5: Behavioral health and substance use services

Humana Healthy Horizons manages behavioral health and substance use services through its provider networks, consisting of appropriately credentialed, licensed and/or certified practitioners, facilities, providers and programs.

Understanding both behavioral and physical health equally affect a person's wellness, Humana Healthy Horizons uses a holistic treatment approach to address behavioral health and substance use. Humana Healthy Horizons integrates behavioral and physical health services with an emphasis on the integration of treatment for co-occurring disorders. We provide a comprehensive range of basic and specialized behavioral health services.

Outpatient services

Outpatient behavioral health and substance use services are essential elements in a comprehensive healthcare delivery system. Humana Healthy Horizons members may access outpatient mental health and substance use services by self-referring to a participating provider, calling Humana Healthy Horizons for a referral, or through acute or emergency room (ER) encounters. Outpatient services include, but are not limited to:

- Screening
- Assessment
- Individual and group therapy
- Medication management
- Psychosocial rehabilitation
- Partial hospitalization program
- Intensive outpatient program
- 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 resources
- 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
- Community support services, including the following (prior authorization may be required depending on service rendered):
  - Psychosocial rehabilitation services
  - Behavior modification —available up to 21 years old
  - Family support—available for families of children up to 21 years old
  - Therapeutic childcare —available up to 6 years old
  - Community integration services—available to adults with severe and persistent mental illness (SPMI)/SUD
  - Peer support services to be rendered by Department of Mental Health (DMH) and Department of Alcohol and Other Drug Abuse Services (DAODAS) providers only

Inpatient services

Humana Healthy Horizons covers behavioral health and substance use inpatient services as applicable per the prior authorization list (PAL) found in the Utilization Management section of this manual. Inpatient services include, but are not limited to:

- Inpatient psychiatric services in a designated hospital unit or free-standing psychiatric hospital
- Detoxification and substance use residential services, in accordance with American Society of Addiction Medicine (ASAM) levels of care

Inpatient services occurring in institutions for mental diseases (IMD) are outlined in the Utilization Management section of this manual. Humana Healthy Horizons is compliant with all 1115 IMD severe mental illness (SMI)/SUD demonstration waiver's special terms and conditions.

Providers, members or other responsible parties can call Humana Healthy Horizons at **855-223-9868 (TTY: 711)** to verify available behavioral health and substance use benefits and seek guidance in obtaining such services. Humana Healthy Horizons' network focuses on improving member health through evidence-based practices. Humana Healthy Horizons' goal is to provide the level of care needed by the member within the least restrictive setting.

Behavioral health screening and evaluation

Humana Healthy Horizons understands PCPs are on the front line of identifying and treating behavioral health issues. Basic behavioral health services may be provided through primary care include, but not limited to, mental health and substance use screenings, prevention, early intervention, medication management, treatment and referral to specialty services.

Humana Healthy Horizons promotes screenings and evaluations to identify behavioral health/substance use problems as well as support member education related to the specific diagnosis/risk factor. Humana Healthy Horizons expects providers to:

- Educate members how to obtain behavioral health services
- Understand members may self-refer to any behavioral health provider without a referral from a PCP or specialty provider

Humana Healthy Horizons requires 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

Provider coordination for behavioral health

Humana Healthy Horizons network providers are required to coordinate care when members experience behavioral health conditions that require ongoing care. PCPs are required to:

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

Behavioral health providers are required to:

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

Providers may reach out to a Humana Healthy Horizons care manager to assist with referrals and/or discuss a screening score or outcome with a licensed Humana Healthy Horizons team member. Providers can call **855-223-9868** and request to speak to a care manager or email **OKMCDCaseManagement@humana.com**, and our CM team will respond as expeditiously as possible.

Coordination of behavioral health treatment

Humana Healthy Horizons believes discharge planning is a key part of treatment and should begin at admission. Discharge plans from behavioral health and substance use inpatient admissions, as well as ER visits, should incorporate the member's needs for continuity with existing behavioral health therapeutic relationships or ensure engagement with appropriate community behavioral health or substance use resources post-discharge to facilitate a smooth transfer of the member to the appropriate level of care. Additionally, Humana Healthy Horizons requires an outpatient follow-up appointment be scheduled prior to a member's discharge from an inpatient behavioral health treatment facility or ER visit. The appointment must occur within seven days of the discharge date. Behavioral health providers are expected to contact members within 24 hours of a missed appointment to reschedule.

Chapter 6: Tribal health providers

Humana Healthy Horizons is here to help Indian Health Care Providers (IHCPs) navigate Medicaid managed care. IHCPs may contact their assigned Provider Relations representative for assistance with billing and reimbursement issues, questions about Humana or Medicaid, answering questions, accessing our extensive training and education materials, or for other help. Our tribal government liaison conducts outreach to the American Indian/Alaska Native (AI/AN) community, is available to assist IHCPs in answering questions and identifies additional community-based resources. Our tribal member concierge unit is a local, one-stop shop for questions and assistance specifically related to AI/AN health issues.

Referrals from ICHPs

In accordance with federal law, Humana Healthy Horizons allows AI/AN members to obtain services covered under the contract from out-of-network IHCPs from whom the AI/AN member is otherwise eligible to receive such services. AI/AN members also may be referred to a participating provider from an IHCP who is outside our network. This includes services furnished by an out-of-network IHCP or through referral under purchase and referred care.

Payment for IHCPs

Federal law provides protection for IHCPs in Medicaid. Providers with questions about these requirements can refer to the "Model Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)" **https://www.medicaid.gov/federal-policy-guidance/downloads/cib121416.pdf**. Humana Healthy Horizons maintains a reference copy of this guidance. Please contact your Provider Relations representative or our tribal government liaison for assistance.

IHCPs bill OHCA directly for eligible services. For questions about these reimbursement requirements, please contact your Provider Relations representative or our tribal government liaison. They can connect providers with Humana resources to assist in navigating the reimbursement process.

American Indian/Alaska Native member protections

In accordance with federal law, Humana Healthy Horizons allows AI/AN members to receive services from an IHCP PCP who is a participating provider and to choose that IHCP as the AI/AN member's PCP if that provider has capacity to provide the services. Humana Healthy Horizons also allows AI/AN members to obtain services covered under this Medicaid contract from out-of-network IHCPs from whom the AI/AN member is otherwise eligible to receive such services. Humana Healthy Horizons also permits an out-of-network IHCP to refer an AI/AN member to a participating provider. This includes services furnished by an out-of-network IHCP or through referral under purchase and referred care.

Please note: AI/AN members are exempt from cost sharing. Providers are prohibited from billing AI/AN members for cost sharing.

Chapter 7: Covered services

Humana Healthy Horizons, through its contracted providers, is required to arrange for the following medically necessary medical and behavioral health benefits for each member, in accordance with the OHCA's policies and rules and federal regulations.

Please note: Not all members are eligible for all benefits. Their eligibility category determines which benefits they are to receive.

Medical and related benefits

Humana Healthy Horizons covers all medical and related benefits outlined in the table below and in accordance with the state plan, Alternative Benefit Plan (ABP) and the 1115 demonstration waiver. Annual benefit limits are tracked on a state fiscal year basis.

Service	Children (younger than 21)	Adults (21 and older)
Advanced practice registered nurse (APRN)	Covered	Covered: Four outpatient visits per month **ABP:** Limit can be exceeded based on medical necessity
Allergy testing	Covered	Covered: Limited to 60 tests over three years **ABP:** Limit can be exceeded based on medical necessity
Alternative treatment for pain management	Covered	Physical therapy when provided in a non-hospital-based setting: • Initial evaluation covered without PA • 12 hours per year, requires PA Chiropractic services: • Initial evaluation covered without PA • 12 visits per year; requires PA Limits can be exceeded based on medical necessity
Ambulance or emergency transportation	Covered	Covered
Ambulatory surgical center	Covered	Covered Reimbursement is outlined in Oklahoma Medicaid state plan
Bariatric surgery	Covered after meeting presurgical evaluation and weight loss requirements; PA required	Covered after meeting presurgical evaluation and weight loss requirements; not covered for the treatment of obesity alone PA required
Certified registered nurse anesthetist and anesthesiologist assistants	Covered	Covered
Chemotherapy	Covered	Covered
Clinic services	Covered Some services may require a PA	Covered Some services may require a PA
Diabetes education	Covered: • 10 hours per first year • Two hours per subsequent year Limits can be exceeded based on medical necessity and under Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Covered: • 10 hours per first year • Two hours per subsequent year **ABP:** Limit can be exceeded based on medical necessity.

Service	Children (younger than 21)	Adults (21 and older)
Diagnostic testing entities	Covered Some services may require PA	Covered Some services may require PA
Donor human breast milk (Effective on or before Nov. 7, 2022)	Covered during the first year of life; services require PA	Not covered
Durable medical equipment (DME) supplies and appliances	Covered Requires prescription by a medical provider; may require PA. Requires use of Oklahoma-based DME/medical supply dealer.	Covered Requires prescription by a medical provider; may require PA. Requires use of Oklahoma-based DME/medical supply dealer.
EPSDT and early intervention services (Including but not limited to: health and immunization history, COVID-19 vaccine counseling, physical exams, various health assessments and associated counseling, lab and screening tests, and necessary follow-up care) (317:30-3-65 – 317:30-3-65.12)	Covered Some services may require PA.	Not covered
Emergency department	Covered	Covered
Eye care to treat a medical or surgical condition	Covered	Covered
Family planning services	Covered	Covered
FQHC and RHC services	Covered	Covered
Genetic counseling and testing	Covered for pregnant members and members meeting medical necessity criteria; may require PA	Covered for pregnant members and members meeting medical necessity criteria; may require PA
Hearing services	Covered; may require PA	Not covered
Home healthcare services	Covered	Covered
Hospice care	Covered for members with a life expectancy of six months or less	Not covered **ABP:** Covered for members with a life expectancy of six months or less
Immunizations as recommended by the Advisory Committee of Immunization Practices	Covered	Covered when medically necessary and not considered a compensable part of the procedure
Infusion therapy	Covered	Covered

Service	Children (younger than 21)	Adults (21 and older)
Inpatient hospital services	Covered	Covered • Inpatient hospital services (inpatient stay): no limit • Inpatient provider services: covered • Inpatient surgical services: no limit • Inpatient rehab hospital services: 90 days per individual, per state fiscal year (SFY) ABP: • Inpatient hospital services (inpatient stay): no limit • Inpatient provider services: covered • Inpatient surgical services: no limit • Inpatient rehab hospital services: 90 days per individual, per SFY Amount limits can be exceeded based on medical necessity.
Laboratory, X-ray, diagnostic imaging, imaging (CT/PET scans, MRIs) services	Covered May require PA	Covered May require PA
Lactation consultant	Covered for pregnant and postpartum members	Covered for pregnant and postpartum members
Lodging and meals for the member and/or one approved medical escort	Covered with PA	Covered with PA
Long-term care hospital services for children	Covered	Not covered
Mammograms	Covered	Covered
Maternal and infant licensed clinical social worker (LCSW) services	Covered for pregnant and postpartum members.	Covered for pregnant and postpartum members.
Nonemergency medical transportation (NEMT)	Covered	Covered
Nurse midwives	Covered under EPSDT	Covered
Nursing facility and intermediate care facility for individuals with intellectual disorder (ICF/IID) services	Covered by contractor for up to 60 days pending the level-of-care determination	Covered by contractor for up to 60 days pending the level-of-care determination
Nutrition services (dietician)	Covered	Covered: up to six hours per year Nutritional services for treatment of obesity are not covered. Services must be expressly for diagnosing, treating, preventing or minimizing effects of illness. **ABP:** Limits can be exceeded based on medical necessity.
Orthotics	Covered	Not covered **ABP:** Covered without limitations when medically necessary
Outpatient hospital and surgery services	Covered	Covered
Parenteral/enteral nutrition	Covered May require PA	Covered May require PA
Personal care services	Covered	Covered

Service	Children (younger than 21)	Adults (21 and older)
Physician and physician assistant services	Covered	Covered: Four outpatient visits per month **ABP:** Four outpatient visits per month; limit can be exceeded based on medical necessity
Podiatry services	Covered	Covered
Post-stabilization care services	Covered	Covered
Pregnancy and maternity services, including prenatal, delivery and postpartum	Covered	Covered
Prescription drugs	Covered	Covered: • Up to six prescriptions per month, including up to two branded drugs without PA • Up to three branded drugs with PA (within the six-prescription limit)
Preventive care and screenings **Female members have direct access to women's health specialists to provide women's routine and preventative health care services in addition to their primary care.**	Refer to EPSDT coverage	Covered as outlined in the state plan for outpatient hospital services, other laboratory and X-ray services, diagnosis and treatment of conditions found, clinic services, screening services, and rehabilitative services. There is not a standalone preventive services benefit package for adults providing coverage for all services identified with an A or B rating by the U.S. Preventative Services Task Force (USPSTF).
Private duty nurse (PDN)	Covered: Up to 16 hours per day, with exceptions made to the 16-hour limit for up to 30 days immediately following hospitalization or the temporary incapacitation of the primary caregiver	Not covered **ABP:** This service is substituted with skilled nursing under the home health services benefit.
Prosthetic devices	Covered with PA	Limited coverage: Only breast prosthesis, support accessories and prosthetic devices inserted during surgery are covered with required PA. **ABP:** Covered without limitations when medically necessary
Public health clinic services	Covered	Covered: Four visits per month **ABP:** Four visits per month; limit can be exceeded based on medical necessity
Radiation	Covered	Covered
Reconstructive surgery	Covered May require PA	Covered: Non-cosmetic breast reconstruction/implantation/removal is covered only when it is a direct result of a medically necessary mastectomy. May require PA.
Renal dialysis facility services	Covered	Covered

Service	Children (younger than 21)	Adults (21 and older)
Routine patient cost in qualifying clinical trials	Covered to the extent that provision of the service would otherwise be covered outside of the participation in the clinical trial, is a covered state plan/1115 waiver service and meets the requirements in OAC 317:30-3-57	Covered to the extent that provision of the service would otherwise be covered outside of the participation in the clinical trial, is a covered state plan/1115 waiver service and meets the requirements outlined in OAC 317:30-3-57
School-based health related services	Covered	Not covered
Telehealth services	Covered	Covered
Therapy services (including physical therapy [PT)], occupational therapy [OT] and speech therapy [ST] services)	OT and PT: • Initial evaluation covered without PA • Treatment requires PA ST: • Evaluation and treatment require PA	Rehabilitative services: • 15 visits per year for each OT, PT and ST (cumulative total: 45 visits) ABP Limit: Habilitative services: • 15 visits per year for each OT, PT and ST (cumulative total: 45 visits) Rehabilitative services: • 15 visits per year for each OT, PT and ST (cumulative total: 45 visits)
Tobacco cessation services and products	Nicotine replacement therapy (NRT) products (including patches, gum, lozenges, inhalers and nasal spray) and Zyban®/bupropion (including combination therapy of these products) are covered. Chantix®/varenicline is covered up to 180 days per 12 months. Tobacco cessation products are covered without duration limits, PA or copayment and do not count against monthly prescription limits. Eight tobacco cessation counseling sessions (99406-99407) with contracted providers per year	Nicotine replacement therapy (NRT) products (including patches, gum, lozenges, inhalers and nasal spray) and Zyban®/bupropion (including combination therapy of these products) are covered. Chantix®/varenicline is covered up to 180 days per 12 months. Tobacco cessation products are covered without duration limits, PA, or copayment and do not count against monthly prescription limits. Eight tobacco cessation counseling sessions (99406-99407) with contracted providers per year
Transplant services	Covered with PA; cornea and kidney transplants do not require PA	Covered with PA; cornea and kidney transplants do not require PA
Urgent care centers/facilities	Covered	Covered: Up to four outpatient visits per month **ABP:** Four outpatient visits per month; limit can be exceeded based on medical necessity
Vision services	Covered under EPSDT with a limit of two eyeglass frames per year	**Adults older than 21 and ABP:** Coverage to treat a medical or surgical condition only; no coverage for routine eye exams

Behavioral health benefits

In addition to the requirements and benefits covered in the previous section, Humana Healthy Horizons also covers behavioral health benefits as outlined in the table below and in accordance with the state plan, ABP and the 1115 demonstration waiver.

Service	Children (younger than 21)	Adults (21 and older)
Applied behavioral analysis (ABA) services	Covered with PA	Not covered
Certified community behavioral health clinic (CCBHC) services	Covered	Covered
Day treatment services	Covered with PA for a minimum of three hours per day for four days per week	Not covered
Inpatient hospital—freestanding psychiatric	Covered with PA	Ages 21-64: Covered with PA, in accordance with the 1115 IMD waiver for a maximum of 60 days per episode Ages 65 and older: Covered with PA
Inpatient hospital – general acute	Covered with PA	Covered with PA
Licensed behavioral health provider (who can bill independently)	Covered with PA	Not covered
Medication assisted treatment (Suboxone® [buprenorphine/ naloxone SL films], vivitrol, methadone)	Covered	Covered
Opioid treatment programs	Covered with PA	Covered with PA
Outpatient behavioral health agency services	Covered with PA	Covered with PA
Partial hospitalization	Covered with PA for a minimum of three hours per day for five days per week	Covered with PA for a minimum of three hours per day for five days per week
Peer recovery support services	Covered for ages 16 through 21 with PA	Covered with PA
Program for assertive community treatment (PACT) services	Covered for ages 18 through 21	Covered
Therapeutic behavioral services, family support and training	Covered for children with severe emotional disturbance (SED) in a systems-of-care wraparound team	Not covered
Psychiatric residential treatment facility	Covered with PA	Not covered
Psychiatrist	Covered	Covered
Psychologist (who can bill independently)	Covered with PA	Covered with PA
SUD treatment (Outpatient, inpatient and residential)	Outpatient substance use treatment: covered with PA Residential substance use treatment: covered in accordance with the Title XIX state plan and accordance with 1115 IMD waiver	Outpatient substance use treatment: Covered with PA Residential substance use treatment: Covered in accordance with the Title XIX State Plan and accordance with 1115 IMD waiver

Service	Children (younger than 21)	Adults (21 and older)
Targeted case management	Covered for targeted populations with PA	Covered for targeted populations with PA
Therapeutic foster care	Covered with PA	Not covered

Cost sharing

Humana Healthy Horizons does not require copayments for medical and behavioral health services as a value-added benefit. Copayments (copays) are required for the following covered services:

Service	Copay required
Prescription drugs and insulin	Medicines on the PDL have a $4 copay for drugs for members 21 and older. Once the member's household meets the 5% cost-share, copays are waived.

The following members are exempt from cost sharing requirements and do not require a copay:

- Children
- Persons receiving pregnancy-related services
- American Indians and Alaska Natives from a federally recognized Indian tribe
- Persons receiving nursing home care
- Persons receiving hospice care
- Persons in the Oklahoma Breast and Cervical Cancer Treatment Program

Humana Healthy Horizons reports member cost sharing according to a process defined by OHCA. OHCA notifies the member and their providers when the 5% aggregate limit is met and they are no longer subject to cost sharing for the remainder of the member's current monthly or quarterly cap period.

Excluded benefits

Dental services, except for dental-related emergency services in the inpatient, outpatient and ambulatory surgery center settings, are reimbursed by OHCA outside of Humana Healthy Horizons' capitation and delivered through the SoonerSelect Dental program. Additionally, Humana Healthy Horizons is not financially responsible for services rendered by IHCPs eligible for 100% federal funding.

If Humana Healthy Horizons is unable to find an in-network provider who meets the member's needs, the member can keep their current provider until either the provider becomes in-network or an in-network provider who meets the member's needs becomes available. Members can receive care from an out-of-network provider if the only in-network provider available has moral or religious objections to provide the service, or the member needs related services which would subject the member to unnecessary risk if received separately.

Value-added benefits

Humana Healthy Horizons offers members extra benefits, tools and services (at no cost to the member) that are not otherwise covered or that exceed limits outlined in the Oklahoma State Plan and the Oklahoma Medicaid Fee Schedules. These value-added benefits (VAB) are more than the amount, duration and scope of those services listed above. In instances where a VAB also is a Medicaid-covered service, Humana administers the benefit in accordance with all applicable service standards pursuant to our contract, the Oklahoma 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
Breast pumps	Female members can receive one non-hospital grade breast pump every two years or one rental of a hospital-grade breast pump if the infant had an inpatient stay in a NICU.

Value-added benefit	Details and limitations
Convertible car seat or portable crib	Pregnant members who enroll and actively participate in our HumanaBeginnings Care Management Program, complete a comprehensive assessment and participate in at least one follow-up call with a HumanaBeginnings Care Manager can select one convertible car seat or portable crib per infant, per pregnancy.
Criminal expungement services	Members 18 and older can receive reimbursement up to $150 for criminal record expungement, as allowed per the Oklahoma State Bureau of Investigation, per lifetime.
Disaster preparedness meals	One box of 14 shelf-stable meals before or after a natural disaster once per year.
Disaster preparedness/relief kit	For members 18 and older, one disaster relief kit per year before or after a natural disaster Kit includes a backpack with food bars, emergency water, hygiene pack, first aid kit, flashlight, rain poncho, disaster guide, whistle, blanket and disposable mask.
Employment physical	For members 18 and older, one employment physical per year
Financial literacy coaching	For members 16 and older, up to six life coaching sessions for money management and budgeting
Fresh produce box	Up to four boxes of in-season, nutritious, fresh fruits and vegetable annually for members identified as food insecure. Plan approval required.
General Educational Development (GED) testing	For members 16 and older, GED test preparation assistance; includes a bilingual advisor, access to guidance and study materials and unlimited use of practice tests. Test preparation assistance, including tutoring, is provided virtually to allow maximum flexibility for members. Also includes test pass guarantee to provide members multiple attempts to pass the test.
Hearing services	For members 21 and older: • One assessment for hearing aids every three years • Once hearing aid per ear and dispensing fee every three years • Two hearing aid fitting/checking visits every three years • 48 batteries per hearing aid per year
Home-based interventions for asthma	Asthmatic members in our CM or disease management programs can receive reimbursement up to $350 per year for allergen-free bedding, an air purifier and/or carpet cleaning. Care manager approval required.
Housing assistance	For members 18 and older, up to $350 per member, per year (unused allowance does not roll over to the next year) to assist with the following housing expenses: • Apartment rent or mortgage payment (late payment notice required) • Utility payment for electric, water, gas or internet (late payment notice required) • Trailer park and lot rent if it is the member's permanent residence (late payment notice required) • Moving expenses via licensed moving company when transitioning from a public housing authority Plan approval required. • Member must not live in a residential facility or nursing facility. • Funds are not be paid directly to the member. • If the bill is in the spouse's name, a marriage certificate may be submitted as proof.
Maternal and infant virtual care	Pregnant members and members with a child up to 1 year old can receive unlimited access to a smartphone application that provides 24/7 access to a proprietary, video-enabled call routing system that allows members to connect with a lactation consultant or a physician extender for on-demand assistance.

Value-added benefit	Details and limitations
Native American traditional medicine	Reimbursement of up to $300 per calendar year for Native American members to help cover costs for traditional and/or ceremonial Native American traditional services. Member is required to provide a signed verification form.
Newborn care kit	For members 0-6 months, one newborn kit per birth; kit includes diaper bag, diapers, wipes, diaper rash cream, baby blanket, thermometer and bulb syringe
Nonemergency medical transportation (NEMT)	One in-state, round trip (two in-state, one-way trips) per day for a parent and/or guardian to visit their child during a NICU or inpatient hospital stay Members using nonemergency medical transportation may be allowed to bring up to three children when childcare is not available. • Total number of passengers, including the driver, cannot exceed five. • Each child must be younger than 13. • Each child must be the member's by birth, marriage, legal adoption, foster child or legal guardianship. Each child must have their own car seat provided by the member as required by Oklahoma state law.
Nonmedical transportation (NMT)	For members 21 and older, 15 round trips (30 one-way trips) up to 45 miles from the member's residence per year for non-medical transportation to grocery store, food bank, social support (e.g., support group meetings, wellness classes), WIC appointments and Medicaid redetermination appointments Up to 15 round trips (or 30 one-way trips) up to 45 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, including community and neighborhood centers, parks, recreation areas and churches.
Over-the-counter (OTC) pharmacy allowance	Up to $30 per-household, per-quarter allowance enables households to purchase products that treat or relieve commonly occurring conditions, including: • Pain relivers • Diaper rash cream • Cough and cold relief medicine • First aid equipment that does not require prescription Unused amounts do not roll over to the next quarter.
Parent/guardian self-care allowance	Reimbursement up to $40 per quarter for members that are a legal parent or guardian of children up to 12 months old to help cover the costs of childcare and enable our new parents/guardians to spend time doing activities independently and relieve stress
Pest control	Reimbursement of up to $200 per household per year per for pest control If member resides with caregiver, they must show proof. Member can provide a copy of the lease agreement that indicates they reside with caregiver. Plan approval required.
Post discharge meal	14 refrigerated home-delivered meals following discharge from an inpatient or residential facility.
Prescription limit waived for adults	The six-prescription per month limit for adult members is waived. All prescriptions are still subject to state and federal requirements for drug utilization review, safety edits, quantity limits and prior authorizations.
Self-monitoring devices – blood pressure monitoring kit	Members 21 and older under care management may receive one digital blood pressure kit once every three years. Kit includes cuff and monitor. Care manager approval required.

Value-added benefit	Details and limitations
Self-monitoring devices – weight scale	Members 21 and older under care management may receive one weight scale every three years. Care manager approval required.
Smartphone services	Members are eligible for one free smartphone through the federal Lifeline program, per household. Members younger than 18 need a parent or guardian to sign up. This benefit covers, per lifetime, one phone, one charger, one set of instructions, unlimited talk minutes, text and high-speed data, and training for the member and the member's caregiver at the first case manager orientation visit if enrolled in CM. Member must make one phone call or send one text message every month to keep benefit. Member may qualify for enhanced benefits through the Affordable Connectivity Program (ACP) that provides unlimited minutes, 10 GB hotspot and unlimited data. Members can opt into this benefit by calling SafeLink at 800-SAFELINK or visiting their website. Benefits are subject to change by the FCC F13 under the Lifeline program.
Sports physicals	For members 6 to 18, one sports physical per year
Vision services	For members 21 and older, one annual eye exam Members can choose one of the following every two years: • Eyeglasses include non-high index polycarbonate lenses and a $100 allowance for the frame • $100 allowance for the cost of contact lenses (members are responsible for all costs over the allowance)
Waived copays	For members 21 and older, waived copays for medical and behavioral health services
Weight management coaching	Weight management coaching program delivers weight management intervention for members 12 and older. After receiving provider clearance, members can complete six weight management coaching sessions with a health coach, approximately one call per month for a period of six months.
Youth academic support	For members in grades K-12, access to online tutoring services up to two hours per week, as well as ACT/SAT test preparation
Youth development and recreation	Members 12 and older can receive reimbursement of up to $200 annually for participation in activities, including: - YMCA - Boys and Girls Club programming - Swim lessons - Computer coding classes - Music lessons

Go365 for Humana Healthy Horizons

Go365 for Humana Healthy Horizons® is a wellness program that offers members the opportunity to earn rewards for taking healthy actions. Most of the rewards are dependent on Humana Healthy Horizons receiving the provider's claim for services rendered.

Humana Healthy Horizons recommends all providers submit their claims on behalf of members within 6 months of the date of service, but no later than March 15, 2025, to process all 2024 claims so members have time to redeem the rewards prior to March 31, 2025. A member has 90 days from one plan year to the next, assuming the member remains continuously enrolled, to redeem their rewards.

Go365 is available to all members who meet the requirements of the program. Rewards are not used to direct the member to select a certain provider. Rewards are non-transferrable to other managed care plans or other programs and have no cash value. E-gift cards may not be used for tobacco, alcohol, firearms, lottery tickets and other items that do not support a healthy lifestyle.

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

Healthy activity	Reward
Breast cancer screening	Annual $25 reward for female members who obtain a mammogram, for members 40 and older
Cervical cancer screening	Annual $25 reward for female members who obtain a Pap test, for members 21 and older
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 who obtain a colorectal cancer screening as recommended by their PCP, for members 45 and older
COVID-19 vaccine	Annual $40 reward for members 5 and older who upload a picture/file of their completed COVID-19 vaccine card, one per year Members who were vaccinated prior to enrollment in Humana Healthy Horizons may upload a vaccination card within 90 days of enrollment to receive the reward. New members that were not vaccinated prior to enrollment in Humana Healthy Horizons have 90 days from completion of vaccination to upload an image of their vaccination card to receive the reward.
Diabetic retinal exam	Annual $25 reward for diabetic members who complete a retinal eye exam, for members 18 and older
Diabetic screening	Annual $50 reward for diabetic members 18 and older who obtain a screening with their PCP for HbA1c and blood pressure
Digital onboarding	One-time $25 reward for downloading Humana Healthy Horizons' mobile Go365 app and completing registration
Flu vaccine	Annual $20 reward for members who receive an annual flu vaccine from their provider or pharmacy, or via self-report when they received a vaccine from another source
Follow up after high-intensity care for SUD	$25 reward for members who received follow-up care within 30 days of an inpatient hospital discharge, residential treatment or detoxification visit for a diagnosis of SUD
Follow up after hospitalization for mental illness	$25 reward for members who received follow-up care within 30 days after a hospital discharge for a diagnosis of select mental illness or intentional self-harm
Health risk screening (HRS)	One-time $50 reward for completing the HRS; must be completed within 30 days of enrollment. Member must opt in to Go365 mobile app to be eligible to receive reward.
Humana papillomavirus (HPV) vaccine	One-time $50 reward for members who receive two doses of the HPV vaccine between their 9th and 13th birthdays, for members ages 9-13
Level-of-care education	Annual $10 reward after watching a short educational video about when to access the ER, for members 19 and older
Notification of pregnancy (NOP)	$25 reward when pregnant members notify Humana Healthy Horizons of pregnancy prior to delivery, once per pregnancy
Postpartum visit	$25 rewards for all postpartum females who complete one postpartum visit within 7 to 84 days after delivery, once per pregnancy
Prenatal visits	Pregnant members can earn $10 per prenatal visit, up to 10 prenatal visits, for a total of up to $100 once per pregnancy
Tobacco cessation program	$25 in rewards for members 13 and older who register for the state tobacco cessation program. $25 in rewards for members 13 and older who complete the state tobacco cessation program, once per lifetime.

Healthy activity	Reward
Weight management program	Members 12 and older who enroll in the weight management program have two opportunities to earn rewards: • $10 in rewards for completing a well-being check-up • $20 in rewards for completing the program
Well-child visits (0-15 months)	Up to $60 reward for members who complete routine well-child visits; members can receive $10 in reward per visit with a 6-visit limit.
Well-child visits (16-30 months)	$20 reward for members who complete routine well-child visits; members can receive $10 reward per visit with a 2-visit limit
Wellness visit	Annual $25 reward for completing an annual wellness visit, for members 3 and older

Early and Periodic Screening, Diagnostic and Treatment

Humana Healthy Horizons provides EPSDT benefits to all members younger than 21. EPSDT includes necessary healthcare, diagnostic services, treatment and other measures described in Section 1905(a) of The Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered during screening, whether such services are covered under the state plan. Please see the EPSDT chapter for more information.

Transplant services

The Humana Transplant Services team helps members and their providers navigate transplant care and make informed decisions by:

- Explaining the benefit structure and helping members maximize their benefits
- Helping members choose a transplant program
- Dedicating transplant care managers for authorization and CM services
- Dedicating specially trained staff to handle claims quickly and efficiently

To reach Humana's team of transplant care managers, please call **866-421-5663**, email **transplant@humana.com** or fax **502-508-9300**. Care managers are available to assist Monday through Friday, 8 a.m. to 5 p.m. Central time. Messages left after hours receive a response the next business day.

Telehealth services

Humana Healthy Horizons encourages providers to use telehealth to provide medically necessary, appropriate, covered services that can be provided virtually. Telehealth has many benefits, including:

- Expanding healthcare accessibility by mitigating barriers to seek in-person care that can include:
  - geographic distance to the member's provider
  - transportation inaccessibility
  - lack of childcare
- Increasing provider revenue
- Improving continuity of care for your patient panel

The restrictions, limitations and coverage that apply to non-telehealth services also apply to telehealth services. However, only certain telehealth codes are reimbursable. A listing of reimbursable telehealth codes can be found on OHCA's website.

Humana Healthy Horizons offers resources regarding how to deploy and offer telehealth services on our unsecured provider website at **humana.com/healthyOK**. You also may reach out to your Provider Relations representative for support or inquiries related to telehealth, including technology requirements and billing and claims submission.

Telehealth should not be used if there are technical difficulties or if the member is uncomfortable or does not understand the process. Telehealth services also must have the same assessment quality as an in-person assessment, and providers should consider whether the health need addressed is appropriate for telehealth.

The following are requirements are for telehealth services:

- Telehealth services must follow OHCA policy, as well as all other applicable state and federal laws and regulations. This includes, but is not limited to, 59 O.S. § 478.1.

- Telehealth visits must be completed in real time using interactive audio and video or audio-only telecommunication, with the member actively participating in the visit. Health service delivery via audio-only telecommunications is applicable to medically necessary covered primary care and other approved health services. For a complete list of reimbursable audio-only health services codes please refer to **www.okhca.org**. For audio-only telecommunications, the member must actively participate in the audio-only telecommunications health service visit as a condition of payment.
- The telehealth visit should be conducted over a secure internet connection and the confidentiality of the member protected. All telehealth services must be Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant.
- Equipment used during the telehealth visit must be sufficient to support the service billed, and the transmission speed and image also must be sufficient. Staff need to be appropriately trained on use of the telehealth visit and equipment.
- For minors, the member's parent or legal guardian must give written consent to the provider prior to services being rendered via telehealth. Written consent must include the provider's name, address and phone number, along with a summary of the services to be provided via telehealth. The type of service, frequency and duration also need to be included. Once prior written consent is given, it is not required for the parent or legal guardian to attend the telehealth visit unless their attendance is therapeutically appropriate. The provider should notify the parent or guardian through a text or email that the telehealth service was provided.
- Members have a right to withdraw from telehealth services at any time.
- Members have access to all medical records, including transmitted medical information.

For reimbursement, the telehealth service must be a covered service and billed with the appropriate modifier.

Chapter 8: Early and Periodic Screening, Diagnostic and Treatment

EPSDT is a federally mandated program developed for Medicaid recipients from birth through the end of the month of their 21st birthday. All Humana Healthy Horizons members within this age range should receive age-recommended EPSDT preventive exams, health screens and EPSDT special services needed to address health issues as soon as identified or suspected. EPSDT benefits are available at no cost to the member.

Humana Healthy Horizons gives providers access to tools that can identify Humana Healthy Horizons-covered patients under their care who may have additional opportunities for care identified in Healthcare Effectiveness Data and Information Set (HEDIS®) measures related to EPSDT services, including well-child visits and immunizations. These tools and reports are updated on a regular basis. On at least a quarterly basis, PCPs receive a list of members who have not yet complied with the EPSDT periodicity requirements so affected PCPs may reach out to those Humana Healthy Horizons-covered patients.

EPSDT preventive services

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

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

EPSDT exam components

EPSDT preventive exam components include:

- Comprehensive health and development history
- Comprehensive unclothed physical examination
- Laboratory tests, including (where indicated) blood-lead level screening/testing, anemia test using hematocrit or hemoglobin determinations, sickle cell test, complete urinalysis, testing for sexually transmitted diseases, tuberculin test and pelvic examination
- Developmental screening/surveillance, including autism screening
- Sensory screenings and referrals for vision and hearing
- Nutritional assessment, including body mass index and blood pressure
- Dental screenings and referrals to a dentist, as indicated (Dental referrals are recommended to start 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 for mothers, integrated into the one-, two-, five- and six-month well-child visits

EPSDT special services

Under the EPSDT benefit, Medicaid provides comprehensive coverage for any service described in section 1905(a) of the Social Security Act. EPSDT special services include coverage for other medically necessary healthcare, evaluations, diagnostic services, preventive services, rehabilitative services and treatments, including:

- 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, regardless of whether those services are covered by Oklahoma Medicaid

Please note, medical necessity is determined on a case-by-case basis, and EPSDT special services used to address medically necessary treatment often require prior authorization. Humana Healthy Horizons considers the child's long-term needs, not only immediate needs, and all aspects of the child's health, including physical, developmental, behavioral, etc., when determining medical necessity.

EPSDT exam frequency

The Humana EPSDT Periodicity Schedule is aligned to the current recommendations of the American Academy of Pediatrics (AAP) and Bright Futures 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 month of the member's 21st birthday)

To view updates to the schedule, please visit **Bright Futures**.

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 childhood immunization schedule recommended by the Centers for Disease Control and Prevention (CDC) and recommended by the Bright Futures/AAP Medical Periodicity Schedule. This schedule is updated annually, and current updates can be found on the **Immunizations**.

Chapter 9: Pharmacy

Humana Healthy Horizons provides coverage of medically necessary medications prescribed by Medicaid-certified, licensed prescribers in the state. Humana Healthy Horizons adheres to state and federal regulations on medication coverage for our members.

Drug coverage

Humana Healthy Horizons and other health plans in the state are required to use a uniform PDL and utilization management (UM) plan developed by OHCA. The PDL includes some preferred branded drugs, as well as preferred diabetic supplies, including blood glucose test strips, lancets, meters, syringes, etc.

Utilization management

The PDL identifies covered drugs and associated drug UM requirements, such as prior authorization, quantity limits, step therapy, etc.

- Prior authorization: The medication must be reviewed using a criteria-based approval process prior to a coverage decision.
- Step therapy: The member must utilize medications commonly considered first-line before using medications considered second- or third-line.
- Drug safety limits: Facilitate the appropriate, approved label use of various classes of medications (e.g., drug interactions, opioid limits, therapeutic duplication).
- Generic substitution: Generic drugs should be dispensed when available. If using a particular brand name is determined to be medically necessary, PA must be obtained.
- Quantity limits: Restrict the maximum quantity of a medication during a certain period of time to help ensure safe use of a medication based on recommended dosing guidelines

Coverage limitations

The following is a list of noncovered (i.e., excluded from the Medicaid benefit) drugs and/or categories:

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

PDL updates

Humana Healthy Horizons may add or remove drugs on the PDL throughout the year as directed by OHCA. We may also change our UM requirements for covered drugs. Examples include:

- Elect to require or not require PA
- Elect to change the quantity limits
- Add or change step therapy restrictions
- Add new guidance or clinical guidelines for a drug from the Food and Drug Administration (FDA)
- Add a generic drug new to the market

Humana Healthy Horizons notifies providers of negative impacts to the PDL at least 30 days in advance.
Please review the current formulary prior to writing a prescription to determine if drug is covered. The PDL is updated regularly; to view the current PDL, go to **Humana.com/DrugLists**. To view current medical and pharmacy coverage policies, please visit **Medical and Pharmacy Coverage Policies**.

Medications administered in the provider setting

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

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

Coverage determinations and exceptions

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

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

The coverage determination decision is based on medical necessity and is communicated within 24 hours after the request is received from the prescriber.

Medication appeals

If Humana denies the member's coverage determination or formulary exception, providers can ask for a review of our decision by making an appeal on behalf of the member. Please review the member grievance and appeals section of this manual for details on how to submit appeals.

If providers prefer to have a discussion with one of our pharmacists or regional medical directors, they may initiate a peer-to-peer request by calling **844-330-7734**, Monday through Friday, 7 a.m. to 5 p.m., Central time and leave a message that includes:

- Prescriber contact information and best time to contact
- Referenced patient name, date of birth and evidence of coverage information
- Prescription drug requested and reason for the call

NOTE: The person-to-person discussion is not considered part of the appeal process and, depending on the outcome, providers may still request a formal appeal.

Electronic prescribing

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

Copay

Medicines on the PDL have a $4 copay for drugs for members 21 and older. After the member's household meets the 5% cost share limit, copays are waived. However, there are no copays for the following members:

- Children 20 and younger
- Native American and Alaskan Native members of federally recognized tribes
- Pregnant women

Continuity of care

We want to make the enrollment or transition into our plan as easy as possible for our members. For drugs that require a coverage determination or formulary exception, we may allow a temporary supply of a drug during the first 90 days of enrollment.

Medication therapy management

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

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

Network pharmacies

Our pharmacy directory gives providers a complete list of network pharmacies that have agreed to fill covered prescriptions for members. Providers and members can access our Pharmacy Directory at **Humana.com/PharmacyFinder**, and members also can find our Pharmacy Finder tool by visiting **Humana.com**.

Members have access to a mail-order pharmacy, which sends their medications directly to their home. For additional information about this option, please visit **Humana.com**.

Over-the-counter health and wellness

Humana Healthy Horizons members have an expanded pharmacy benefit, which provides $30 per household per quarter to spend on OTC health and wellness items. The unused amount does not roll over to the next quarter. UPS or the U.S. Postal Service delivers OTC items and other approved products within 10-14 working days after the order is received.

There is no charge to the member for shipping. Providers can find a full list and order form for OTC health and wellness items available for mail delivery at **Humana.com**. If you have questions about this mail-order service, please call the CenterWell Pharmacy at **855-211-8370 (TTY: 711)**.

Pharmacy lock-in program

The Oklahoma lock-in program (OLIP) is designed for Humana Healthy Horizons members who need help managing their use of prescription medications. It is intended to limit overuse of benefits and reduce unnecessary costs to Medicaid while providing an appropriate level of care for the member.

Members who meet the program criteria are locked into one pharmacy location, one PCP and up to two specialty providers, as appropriate. Members receive written notification from Humana Healthy Horizons stating they meet the criteria for OLIP. Members must respond within 30 days of the mail date of the notification to choose a pharmacy and a provider from which to receive services or selections will be made for them. The member receives an additional letter with the following information:

- Name of the designated provider and pharmacy
- Instructions for requesting a change to the designated pharmacy and/or provider
- PCP selection criteria
- Reason for restriction
- Effective date of program enrollment
- Length of limitation
- Rights to appeal the decision

Please note: Members diagnosed with sickle cell disease, cancer, or receive hospice care, reside in an institutional setting, or are younger than 18 are exempt from OLIP.

Chapter 10: Utilization management

Utilization management department

The utilization management (UM) department performs all UM activities including prior authorization, concurrent review, discharge planning and other related UM activities for medical and behavioral health. We monitor inpatient and outpatient admissions and procedures to ensure appropriate medical care is rendered in the most appropriate setting, using the most appropriate resources. We also monitor the coordination of care to ensure its continuity. Referrals to the Humana Healthy Horizons CM team are made as needed. Humana Healthy Horizons completes an assessment of satisfaction with the UM process on an annual basis, identifying areas for improvement opportunities.

UM review determinations

UM helps maintain the quality and appropriateness of healthcare services provided to Humana Healthy Horizons members. UM 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 resulting 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 consistent with our responsibility to our members. We place appropriate limits on a service based on criteria applied under the Medicaid state 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 who have ongoing or chronic conditions, or who require long-term services and support, are authorized in a manner reflecting the member's ongoing need for such services and support.

Prior authorization

Prior authorization (PA) is the process through which the PCP or other healthcare provider obtains approval from the plan as to whether an item, drug or service is covered.

Requests for PA should be made as soon as possible but at least 14 days in advance of the service date. If PA is required and not obtained, it may result in a reduction or denial of payment. Services provided without PA also may be subject to retrospective review. When retrospective reviews are performed, clinical information should be included to perform a medical necessity review. A summary of why PA was not obtained should also be included in the review.

Our PA list can be found at **Humana.com/PAL**. Please note the PA list is subject to change. Changes to PA requirements are posted to **Humana.com/PAL** a minimum of 45 days prior to the effective date of the change. Medical services and behavioral health/SUD services are evaluated for addition to or removal from the PA list, utilizing the same factors in accordance with the Mental Health Parity Addiction and Equity Act.

If a member requires medically necessary services from a nonparticipating provider, the provider may call the Provider Services Contact Center to obtain prior authorization.

Court-ordered services

Humana Healthy Horizons provides medically necessary, covered, court-ordered behavioral health services pursuant to issued court order(s). These services are furnished in the same manner as services furnished to other members.

Referrals

Humana Healthy Horizons has policies and procedures in place for PCPs to make referrals for their Humana Healthy Horizons-covered patients to ensure timely appropriate care for their patients' conditions. Humana Healthy Horizons does not require a referral to in-network specialist. The member may travel to a border state within 50 miles of the Oklahoma border (Arkansas, Colorado, Kansas, Missouri, New Mexico or Texas) to receive covered services by an Oklahoma SoonerCare-licensed provider. If Humana Healthy Horizons exhausts all in-state provider options and demonstrates unavailability for a medically necessary service, Humana Healthy Horizons provides these services through an out-of-state provider. Through the referral process, Humana Healthy Horizons allows members direct access to non-participating specialist when it is determined, through assessment by an appropriate healthcare professional, that a member needs direct access for treatment or regular care monitoring.

Members are permitted to self-refer, at minimum, to the following services:

- Behavioral health services, including SUD treatment
- Vision services
- Emergency services
- Family planning services and supplies
- Prenatal care
- Department of Health providers, including mobile clinics
- Services provided by IHCPs to AI/AN members

Providers should offer education to members regarding the possible consequences of self-referrals, including delays in receiving care. If a member attempts to receive a non-covered service, providers must inform the member the cost of the service and how much they may be billed prior to providing the service.

Humana Healthy Horizons has policies and procedures in place to conduct random medical record review audits on primary provider charts that include referral and result elements.

As part of the CM core processes, the primary care manager coordinates appointments, including second opinion requests from the member or authorized representative/caregiver(s) and in collaboration with the UM team, as well as tracking any and all referrals and outcomes of such. Members successfully contacted regarding referral support assistance receive aid in coordinating referral needs with the PCP and scheduling follow-up appointments. They are given information on Humana Healthy Horizons' 24-hour nurse line and offered CM services to support coordination needs. CM follows up with a member based on their preference to ensure referral needs are met and appointment(s) completed.

Second 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:

- The provider must participate in the Humana Healthy Horizons network. If an in-network provider is not available, Humana Healthy Horizons arranges for the member to obtain a second opinion and facilitate the referral process.
- The provider must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- The 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.

Out-of-network care

Humana Healthy Horizons authorizes out-of-network care, based on medical necessity, when a network provider is not available to provide members with the medically necessary covered medical and behavioral health services in a timely manner. Humana Healthy Horizons assists with care coordination for the member if needed.

Notification requirements

Notification refers to the process of the physician or other healthcare provider notifying Humana Healthy Horizons of the intent to provide an item, drug or service. Humana Healthy Horizons may request notification, as this helps coordinate care for members. This process is distinguished from PA as it does not result in an approval or denial.

- Observation: Providers can maintain members for more than 23 hours in observation if the member has not met criteria for admission, but the treating provider believes allowing the member to leave the facility would likely put the member at serious risk. The observation period cannot last more than three days or 72 hours. Humana Healthy Horizons does not require PA for observation stays. However, notification is requested so we can assist with discharge planning and follow up with the member for any needs.
- Inpatient notification requirements: Humana Healthy Horizons requires providers to submit notification of all inpatient admissions within one business day of the date of admission.

Services not requiring PA

Some services do not require PA from Humana Healthy Horizons. These services include, but are not limited, to:

- Emergency
- Certain behavioral health services, including:
  - Crisis services
  - Medication-assisted treatment (MAT)
  - Programs for Assertive Community Treatment (PACTs)
  - Urgent services

Requesting PA

To initiate a preauthorization, notification or referral request, providers can:

- Visit Availity Essentials at **Availity.com** and complete an authorization request.
- Call **855-223-9868** and follow the menu prompts for authorization requests.
- Fax the request to **833-558-9712**.

For pharmacy PA information, refer to the pharmacy section of this manual.

To simplify the PA process, Humana Healthy Horizons utilizes state-approved PA forms. These forms can be found online at **www.humana.com/healthyOK**.

When requesting an authorization, please provide the following information:

- Member/patient name and Humana member ID number
- Provider name, National Provider Identifier (NPI) and Tax ID number (TIN) for ordering/servicing providers and facilities
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider, if applicable
- Clinical information to support the medical or clinical necessity of the service
- Admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs, if inpatient admission is requested
- For inpatient services:
  - Planned date of admission, servicing and requesting provider and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, all appropriate clinical review and anticipated discharge needs
- For outpatient services:
  - Planned date of service, name of requesting and servicing provider and facility (if applicable), diagnosis, procedure or service planned and anticipated follow-up needs after discharge

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 as a result of a provider not following requirements listed in this manual.

Medical necessity criteria

For those requests for service that require PA or clinical review, Humana Healthy Horizons uses the following hierarchy of guidelines to make medical necessity determinations for outpatient and inpatient care, in both physical and behavioral health settings:

- Federal or state regulations
- Nationally accepted evidence-based clinical guidelines, including MCG (formerly Milliman Care Guidelines), ASAM Level of Care Adolescent Guidelines and ASAM Patient Placement Criteria (ASAM Admission Guidelines)
- Humana clinical policies

For requests for service that are not included in the guidelines listed above, additional information the clinical reviewer considers includes:

- Clinical practice guidelines and reports from peer-reviewed medical literature
- Professional standards of safety and effectiveness recognized in the U.S. for diagnosis, care or treatment
- Medical association publications
- Government-funded or independent entities that assess and report on clinical care
- Decisions and technology publications, such as Agency for Healthcare Research and Quality, Hayes Technology Assessment, Cochrane reviews, National Institute for Health and Care Excellence, etc.
- Published expert opinions
- Opinion of healthcare professionals in the area of specialty involved
- Opinion of attending provider
- EyeMed coverage guidelines and policies (for vision coverage criteria)

These guidelines are intended to allow Humana Healthy Horizons to provide all members with care consistent with national quality standards and evidence-based guidelines. These guidelines are not intended as a replacement for a provider's expertise; they are to provide guidance to providers related to medically and clinically appropriate care and treatment. If a member's clinical information does not meet the criteria for approval, the case is forwarded to a medical director for further review and determination. Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested is made by a licensed physician who has appropriate clinical expertise in treating the Medicaid managed care member's condition or disease.

Notice of adverse benefit determination letters include instructions on how to request all criteria used in making decisions.

Time frames and notifications for responding to PA requests

- Standard: Notice of decision is given as expeditiously as the member's health condition requires, but no later than 72 hours following receipt of the request for service.
- Expedited: When a provider indicates or Humana Healthy Horizons determines following standard time frames could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, Humana Healthy Horizons completes an expedited authorization as expeditiously as the member health condition requires but no later than 24 hours after receipt.
- Extension: With either a standard or expedited request, the member or their provider may request an extension up to 14 calendar days. Humana Healthy Horizons may request an extension up to 14 calendar days from the receipt of the request and at least 48 hours for an expedited request to complete. If the member did not request the extension and an extension is granted, Humana Healthy Horizons sends a written notice of the extension to the member and includes the reason for the extension and details regarding their right to file a grievance.
- Concurrent review: Concurrent requests are requests in which the member is in the process of receiving the requested medical care or services, even if Humana Healthy Horizons did not previously approve the earlier care. Notice of decision is given as expeditiously as the member's health condition requires, but no later than one business day after receiving all information and not to exceed 72 hours from the date of request.
- Behavioral health decision: All inpatient behavioral health admissions are decided within 24 hours of receipt of request.
- Retrospective review: PA is required to ensure that services provided to members are medically necessary and appropriately provided. If providers fail to obtain PA before services are rendered, they have 30 days from the date of service, or inpatient discharge date, or the date of receipt of the primary insurance carrier's Explanation of Payment (EOP), to request a retrospective review of medical necessity. Clinical information supporting the service must accompany the request. Humana Healthy Horizons ensures the retrospective review process evaluates suspended claims within 14 days or earlier, if feasible, and delivers the decision on coverage to the provider no later than the next business day after a decision is reached.

Peer-to-peer consultations

Providers may request a peer-to-peer consultation when Humana Healthy Horizons denies a PA request. The peer-to-peer consultations are conducted among healthcare professionals who have clinical expertise in treating the member's condition, with the equivalent or higher credentials as the requesting/ordering provider. The peer-to-peer consultation must clearly identify what documentation the provider must send to obtain approval of the specific item, procedure

or service, or a more appropriate course of action based on accepted clinical guidelines. If providers want to request a peer-to-peer discussion on a determination with a Humana Healthy Horizons physician reviewer, they can email OKMCDP2PRequest@humana.com or fax **877-217-9199**. The peer-to-peer request must be made within 15 business days of the determination.

Reconsiderations

If providers are not satisfied with an adverse decision or action, they may request a reconsideration. Reconsideration is the process Humana Healthy Horizons uses to review additional clinical documentation from the provider to determine if a denial or partial denial should be overturned and approved, based on medical necessity criteria.

If providers request a reconsideration, they must submit additional information to Humana Healthy Horizons (via Availity Essentials, fax **877-217-9199**, or email OKMCDP2PRequest@humana.com within 15 business days of the date of the adverse determination to facilitate the reconsideration process. Humana Healthy Horizons reviews all new clinical information for reconsideration requests and renders a decision based on the new documentation. If the reconsideration request is received with no new clinical information or receipt is beyond the 15-business day requirement, the original decision stands. Humana Healthy Horizons resolves reconsideration requests and sends a reconsideration resolution notice to the provider within 5 days. The reconsideration process does not prohibit the provider from requesting an appeal. Please reference the provider complaints system section of this manual for further details.

Transition of care

In the best interest of our members and to promote positive healthcare outcomes, we support and encourage the continuity and coordination of care between medical providers as well as between behavioral health providers. Our members' health is always our first priority.

Humana Healthy Horizons honors previously approved care authorizations for 90 days from the day prior to the member's enrollment date with the plan. During this 90-day COC period, we do not deny PAs on the basis that an authorizing provider is not in network, and payments to nonparticipating providers are made at the current Medicaid fee schedule rate.

In addition to honoring existing PAs for 90 days, Humana Healthy Horizons has procedures in place to address COC for members with special conditions. Members with these special health conditions and treatments include, but are not limited to:

- Pregnant women with medically necessary prenatal, delivery and postnatal care, through the postpartum check-up within six weeks of delivery
- Chemotherapy and radiation services
- Dialysis
- Major organ or tissue transplant services
- Bariatric surgery
- Synagis® treatment
- Hepatitis C (treatment and medication)
- Terminal illness

Children receiving private-duty nursing (PDN) services may continue to receive services indefinitely until or unless the member has a comprehensive assessment and determines the appropriate level of PDN services as a component of their overall care plan. The PDN agency must continue to obtain and provide PDN orders and treatment plan to maintain the authorization in 60-day increments until transition is complete. Children receiving PDN services also receive specific transition notification and assistance, including:

- Continuation of hemophilia services from their current hemophilia provider up to 90 days
- Continuation of behavioral health services with their current behavioral health treating provider for up to 90 days
- Continuation of DME services — Humana Healthy Horizons coordinates and ensures that DME or supplies authorized and ordered but not received prior to the member's enrollment with Humana Healthy Horizons are received without undue delay.
- Continuation of approved medication step-therapy protocols with current medications for 90 days

Humana Healthy Horizons honors OHCA's negotiated payment rate for members who receive out-of-state services and/

or meals and lodging assistance.

Humana Healthy Horizons allows members to continue to see nonparticipating providers during this period, until they can be reasonably transferred to a participating provider without impeding service delivery necessary to maintain the member's health. If a participating provider is not available to meet the member's needs, Humana Healthy Horizons allows members to retain their current provider until the provider becomes a participating provider or one who meets the member's needs becomes available. Members are permitted to receive care from nonparticipating providers if:

- The only available participating provider for the member does not, because of moral or religious objections, provide the services the member seeks.
- The member's PCP or other provider determines the member needs related services that would subject the member to unnecessary risk if received separately, and not all these services are available in-network.
- OHCA determines other circumstances warrant out-of-network treatment.

Discharge planning

Humana Healthy Horizons believes discharge planning is a key part of treatment and should begin at admission. Our UM staff reviews appropriateness of discharge planning as part of the clinical review to ensure the appropriateness of the member's transition plan from inpatient care to higher levels of care.

Humana Healthy Horizons is available to assist coordination of care when a member is discharged from a facility or transferred from one level of care to another to ensure the member's successful transition. The Humana Healthy Horizons inpatient UM nurse works with the member, the member's authorized representative, their PCP, their facility care team and other providers, as appropriate. UM nurses work with facility discharge planners to complete the discharge planning assessment. When a member is in care management, the care manager is notified of the admission. If the member transfers from one facility to another, the UM nurse works with the facility, as needed. If the member requires assistance at home, the discharge planner works with the care manager to ensure their needs are met.

Chapter 11: Claims

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

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

Claim submissions

Claims, including initial claims, must be submitted within six months from the date of service or discharge. Corrected claims must be submitted within 12 months from date of service or discharge. Humana does not pay claims with incomplete, incorrect or unclear information.

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

- Faster claims processing and payment
- Reduced probability of errors or missing information from reduced manual processes
- Faster feedback on claims status
- Access to online or electronic remittance information
- Reduced risk of lost or stolen checks

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

- Patient (member) name
- Patient address
- Insured's ID number: Be sure to provide the complete Humana member ID for the patient.
- Patient's birth date: Always include the member's date of birth so we can identify the correct member in case we have more than one member with the same name.
- Place of service: Use standard Centers for Medicare & Medicaid Services (CMS) location codes.
- International Classification of Diseases, Tenth Edition, Clinical Modification (ICD-10-CM) diagnosis code(s)
- HIPAA-compliant Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code(s) and modifiers, when modifiers are applicable
- Units, where applicable (Anesthesia claims require number of minutes.)
- Date of service: Please include dates for each individual service rendered; date ranges are not accepted, even though some claim forms contain from/to formats. Please enter each date individually.
- PA number, when applicable: A number is needed to match the claim to the corresponding PA information. This is only needed if the service provided required a PA.
- NPI and TIN: Please refer to the location of NPI, TIN and member ID number section.
- Federal 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 OHCA Master Provider List (MPL), billing and rendering addresses that match the OHCA MPL
- Signature of provider or supplier, including degrees of credentials. The billing provider or authorized representative must sign and date this field. Include the date the claim was created. A signature stamp is acceptable; however, the statement "signature on file" is not allowed.

Electronic funds transfer/electronic remittance advice

Electronic claims payment offers several advantages over traditional paper checks. With EFT, Humana Healthy Horizons claim payments are deposited directly in the bank account(s) of your choice. By enrolling for EFT, you are also enrolled for our ERA, which replaces the paper version of your remittance advice.

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

EFT/ERA enrollment through Humana

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

To access this tool:

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

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

EFT payment transactions are reported with file format CCD+, which is the recommended industry standard for EFT payments. The CCD+ format is a National Automated Clearing House Association (ACH) corporate payment format with a single 80-character addendum record capability. The addendum record is used by the originator to provide additional information about the payment to the recipient. This format is also referenced in the ERA (835 data file). Contact your financial institution if you want 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 explanation of review (EOR). Humana Healthy Horizons delivers 5010 835 versions of all ERA remittance files compliant with HIPAA. Humana Healthy Horizons uses Availity Essentials as the central gateway for delivery of 835 transactions. You can access remittance through your clearinghouse or through the secure provider tools available in Availity Essentials.

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

Submitting electronic transactions

Provider portal

Humana Healthy Horizons partners with Availity Essentials to allow providers to reference member and claim data for multiple payers using one login. Availity Essentials provides the following functions:

- Eligibility and benefits
- Access certificate of coverage
- Submit preauthorization and referral requests
- Check status of preauthorization and referral requests
- Access plan of care
- Access member summary
- Respond to medical record requests
- Access claim status
- Access claim submission
- Submit of disputes and appeals
- Review remittance advice
- Manage overpayments
- Request ERA/EFT enrollment
- Access provider directory
- Access Humana-specific applications, resources and news

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

For information regarding electronic claim submission, contact your local Provider Relations representative or visit **Humana.com/Providers** and choose "Claims Resources" then "Electronic Claims & Encounter Submissions," or log into Availity Essentials at **Availity.com**.

Electronic data interchange clearinghouses

Electronic data interchange (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, you must work with an electronic claim clearinghouse. Humana Healthy Horizons currently accepts electronic claims from Oklahoma Medicaid providers through the clearinghouses listed below. Please contact the clearinghouse of your choice to begin electronic claim submission.

When filing an electronic claim, you will need to use one of the following payer IDs:
- 61101 for fee-for-service claims
- 61102 for encounter claims

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

Availity Essentials	**Availity.com**	**800-282-4548**
TriZetto	**Trizetto.com**	**800-556-2231**
Change Healthcare	**Changehealthcare.com**	**800-792-5256**
SSI Group	**Thessigroup.com**	**800-820-4774**

Encounter submission and remediation

Humana Healthy Horizons submits 100% of its encounter data, including capitated arrangements, to OHCA for services rendered to a member that resulted in a paid, denied, corrected, voided or zero-paid claim. We also submit encounter data in accordance with the OHCA accuracy standard of 95% for submitted and accepted encounters.

Humana Healthy Horizons collects and submits encounter data to OHCA via the EDIFECS system compliant with 05010 HIPAA transactions. Humana Healthy Horizons uses a customized version of the EDIFECS transaction management platform to manage and monitor encounter submission and resubmissions. This is a single solution for submitting, tracking and error correcting. All failed edits/errors, adjustments and voids are categorized based on Humana-defined logic and distributed to the respective areas.

Humana Healthy Horizons utilizes EDI response (acknowledgement) files to determine if files were successfully loaded. Humana Healthy Horizons corrects and resubmits files that fail to load within seven days of the original submission attempt. Humana Healthy Horizons also corrects and resubmits previously denied encounter data that can be remedied within 30 calendar days after the initial encounter reporting due date.

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 of ICD-10 CM code implementation in 2015. The new standard is the HIPAA 5010 format.

The following transactions are covered under the 5010 requirement:
- 837/837I claims encounters
- 276/277 claim status inquiry
- 835 electronic remittance advice
- 270/271 eligibility
- 278 PA requests
- 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 standard code sets.
- HCPCS, which includes:
  - CPT codes, available from the **American Medical Association**
  - HCPCS Level II codes, available from the **Centers for Medicare & Medicaid Services**
  - National Drug Codes (NDC), available from the **U.S. Food and Drug Administration**
- ICD-10-CM, available from the **Centers for Disease Control and Prevention**

- International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS), available from the **Centers for Medicare & Medicaid Services**

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.

Unlisted CPT/HCPCS codes

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

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

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

Paper claim submissions

For the most efficient processing of your claims, Humana Healthy Horizons recommends you submit all claims 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 the UB92 form for facilities

Paper claim submission must use 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 can be found on **Nucc.org**
- UB-04 form instructions can be found on the **CMS website**

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

Humana Healthy Horizons also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plan organizations.

Local or proprietary codes are no longer allowed.

Please mail all completed paper claim forms to Humana Healthy Horizons at the following address:
Humana Claims Office
P.O. Box 14359
Lexington, KY 40512-4359

Instructions for including required information when using NDC on paper claims:

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

Tips for submitting paper claims:

- Electronic claims are generally processed more quickly than paper claims.
- If you submit paper claims, we require the most current version of the form, as designated by CMS and NUCC.
- No handwritten claims or super bills, including printed claims with handwritten information, are accepted.
- Use only original claim forms; do not submit claims that were photocopied or printed from a website.
- Fonts should be 10 to 14 point (capital letters preferred) in black ink.
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.

- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- Federal TIN or provider SSN is required for all claim submissions.
- All data must be updated and on file with the OHCA MPL, including TIN, billing and rendering NPI, addresses and taxonomy codes.
- COB paper claims require a copy of the EOP from the primary carrier.

Out-of-network claims

Humana Healthy Horizons established guidelines for payments to out-of-network providers for preauthorized medically necessary services. Except as otherwise precluded by law and/or specified for IHCPs, FQHCs, RHCs and certified community behavioral health clinics, services are reimbursed at 90% of the Oklahoma Medicaid fee schedule. If the service is not available from an in-network provider and Humana Healthy Horizons makes three documented attempts to contract with an out-of-network provider, Humana Healthy Horizons may reimburse that provider less than the Medicaid fee-for-service rate.

Claim processing guidelines

Timely filing

- You have six months 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 other insurance and Humana Healthy Horizons is secondary, Humana Healthy Horizons recommends providers submit for secondary payment within six months from the other insurance payment date.

COB

- COB requires a copy of the appropriate remittance statement from the primary carrier payment that includes:
  - Primary carrier's payment information (for electronic claims)
  - EOB from primary carrier (for paper claims)

For a non-Medicare primary payer, an appropriate remittance statement must be received within one year from date of service or discharge. If a claim is denied for COB information needed, the provider must submit the appropriate remittance statement from the primary payer within the remainder of the initial claims timely filing period.

Newborn claims

All claims for newborns must be submitted using the newborn's Humana member ID number. Newborn infants are deemed eligible for Medicaid until 1 year old (when renewal becomes necessary) with Humana Healthy Horizons. Do not submit newborn claims using the mother's identification numbers; in those instances, the claim is denied.

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) systems to electronically monitor, track and confirm services provided in the home setting. Providers must ensure services are provided as specified in the member's care plan; are in accordance with the established schedule, including the amount, frequency, duration and scope of each service; provide those services in a timely manner; and work with Humana Healthy Horizons to identify and immediately address service gaps including, but not limited to, late and missed visits. To comply with the 21st Century Cures Act, improve patient care, reduce costs, minimize fraud, waste and abuse, and retain funding, Oklahoma uses Authenticare as the state EVV vendor. Home health providers can view Oklahoma EVV policy details, including Authenticare contact information, by visiting **Oklahoma's Human Services website**.

Other claim requirements:

- Abortion, sterilization and hysterectomy procedure and initial hospice claims submissions must have consent forms attached. The forms can be found at **https://oklahoma.gov/ohca/providers/forms.html**.
- 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.
- Home health providers are required to bill the electronic HIPAA standard institutional claim transaction (837) or the provider can bill a paper form CMS-1450, also known as the UB-04. These claims are processed according to claims guidelines and processing included in the **Oklahoma MDC Provider Manual**.

Claims compliance standards

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

- Humana pays 90% of all clean claims submitted from providers within 14 calendar days from the date of receipt.
- Humana pays 99% of all clean claims from providers within 90 calendar days of the date of receipt.

Humana Healthy Horizons adheres to the following guideline regarding acknowledgement and payment of all submitted claims for services:

- Issues payment for a clean paper or electronic claim within 45 calendar days following the later of receipt of the claim or the date on which Humana Healthy Horizons is in receipt of all information needed, and in a format required for the claim to constitute a clean claim, and is in receipt of all documentation requested to:
  - Determine that such claim does not contain any material defect, error or impropriety
  - Make a payment

Humana Healthy Horizons maintains a system for determining the date claims are received. Claim acknowledgement is sent electronically to either the provider or the provider's designated vendor for the exchange of electronic healthcare transactions. The acknowledgement 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 to either the provider or the provider's designated vendor for the exchange of electronic healthcare transactions:

- within 20 business days of the submission of the claim if it was submitted electronically
- within 45 business days of the claim if it was submitted via paper

Nothing contained in this section is intended or may be construed to alter Humana Healthy Horizons' ability to request clinical information reasonably necessary for the proper adjudication of the claim or for the purpose of investigating fraudulent or abusive billing practices.

Claim status

Providers can track the progress of submitted claims at any time through Availity Essentials at **Availity.com**. Claim statuses are updated daily, and Availity Essentials offers information on claims submitted in the previous 18 months. Searches can be done by member ID, claim number or date of service.

You can find the following claim information on Availity Essentials at **Availity.com**:

- Payee ("Payment To")
- Check/remit date
- Payment type (check/EFT/balance of payment [BOP])
- EFT deposit date
- Provider TIN
- Provider NPI
- Paid amount

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

Humana Healthy Horizons extends each provider the opportunity for a meeting with a Humana representative if a clean claim remains unpaid in violation of the Oklahoma 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. You also can refer to the provider complaints section of this manual for additional information.

Code editing

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

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

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

Humana Healthy Horizons develops claims processing procedures under its sole discretion based on review of correct coding initiatives, national benchmarks, industry standards and industry sources, including the following (and any successors of the same):

- OHCA 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
- Food and Drug Administration (FDA) guidance
- Medical and surgical specialty societies and associations
- Industry-standard UM criteria and/or care guidelines
- Humana's medical and pharmacy coverage policies
- Generally accepted standards of medical, behavioral health and dental practice, based on credible scientific evidence recognized in published, peer-reviewed literature

Changes to any one of the sources may lead Humana Healthy Horizons to modify current or adopt new claims processing procedures. These claims processing procedures may result in an adjustment or denial of reimbursement, a request for the submission of relevant medical records prior to or after payment, or the recoupment or refund request of a previous reimbursement. You can access additional information at **Humana.com**.

An adjustment in reimbursement due to claims processing procedures is not an indication that the service provided is not covered. Providers can dispute any adjustment produced by Humana Healthy Horizons' claims processing procedures by submitting a timely dispute to Humana Healthy Horizons. For additional information, see the Provider Disputes section of this manual.

Humana Healthy Horizons makes regular updates to code editing methodologies and publishes these updates, including the rationale used for the changes, on the first Friday of each month at **Humana.com/Edits**.

Prepayment reviews for fraud, waste or abuse purposes

Humana Healthy Horizons (or its designee) conducts prepayment reviews of healthcare providers' records related to services rendered to Humana Healthy Horizons members. During these reviews, providers are asked to allow Humana access to medical records and billing documents that support charges billed. For more information, please refer to the fraud, waste and abuse section of this manual.

Claim payment

Humana Healthy Horizons prices each billed service using the fee schedule or contracted rate for a provider when calculating the amount due. Humana Healthy Horizons then sends an ERA or mails an EOR that includes a payment explanation. Humana Healthy Horizons adheres to state and federal requirements pertaining to payments of specific provider types.

Humana Healthy Horizons also applies appropriate national and commercial standards to code/code set(s) submitted and related clinical standards for a claim received electronically or on paper. Humana Healthy Horizons expect submitters to comply with applicable HIPAA requirements, including the use of HIPAA-mandated code sets (e.g., HCPCS Level II, CPT and ICD-10-CM). To that end, HIPAA standards are applied to all Humana Healthy Horizons claims received electronically.

To determine unit prices for a specific code or service, please consult CMS' Medicaid NCCI Policy Manual. Humana Healthy Horizons uses coding industry standards, including the AMA CPT manual, NCCI and relevant guidance from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including, but not limited to:

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

Suspension of provider payments

A network provider's claim payments are subject to suspension if OHCA determines there is a credible allegation of fraud, in accordance with 42 C.F.R. 455.23.

Claims overpayments

Providers must report to Humana Healthy Horizons all service claim overpayments for medical services rendered to Medicaid managed care plan members, in accordance with Humana Healthy Horizons' contract with OHCA, within 60 days of identification of the overpayment. Regardless of agreement specifics, the provider or subcontractor must submit such claims after the date on which the overpayment was identified and notify Humana Healthy Horizons in writing of the reason for the overpayment as required by 42 CFR 438.608.

Refund checks for overpayments can be mailed to:
Humana Healthcare Plans
P.O. Box 931655
Atlanta, GA 31193-1655

Humana Healthy Horizons reports all overpayments to OHCA Program Integrity. These reports include all unsolicited provider refunds.

Third-party liability

Third-party liability (TPL) refers to the legal responsibility of third parties to pay healthcare costs before Medicaid. Providers are required to identify TPL coverage for a Humana Healthy Horizons-covered patient, including, but not limited to, Medicare, private healthcare insurance and long-term care insurance. Claims should be submitted to a patient's TPL coverage for payment before submitting to Humana Healthy Horizons. Humana Healthy Horizons reduces its payments based on TPL coverage payments made for covered services. If Humana Healthy Horizons pays a claim but it's later determined that the claim should be first processed by a third party, Humana Healthy Horizons works to recover the liability from the responsible third party. If this recovery effort involves estate recovery or third-party subrogation, OHCA works to recover the liability.

If Humana Healthy Horizons determines the probable existence of a TPL resource, Humana Healthy Horizons processes the claim as secondary coverage. If Humana Healthy Horizons cannot confirm a TPL resource is responsible for payment, Humana Healthy Horizons denies the claim. However, Humana Healthy Horizons pays claims then bills the member's TPL coverage only for:

- Preventive pediatric services, including EPSDT
- Child support claims, when a provider has waited 100 days from the date of service without receiving payment before billing Medicaid

Coordination of benefits

Humana Healthy Horizons collects COB information for our members. This information helps ensure Humana Healthy Horizons pays claims appropriately and complies with federal regulations that stipulate Medicaid programs are the payer of last resort.

While Humana Healthy Horizons tries to maintain accurate information at all times, such as information from other providers, subcontractors and OHCA's contractors, Humana Healthy Horizons relies on numerous sources for information updated periodically, and some updates may not fully reflect on Availity Essentials at **Availity.com**.
Please ask Humana Healthy Horizons members for all healthcare insurance information at the time of service.
You can search for COB information on Availity Essentials at **Availity.com** by:

- Member number
- State Medicaid number/Medicaid Management Information System (MMIS) number

Providers can use Availity Essentials to check member's COB information who were active with Humana within the last 12 months.

Coordination of benefits overpayment

When providers receive a payment from another carrier after receiving payment from Humana Healthy Horizons for the same items or services, Humana Healthy Horizons considers it an overpayment. Humana Healthy Horizons provides written notice to the provider at least 30 business days before an adjustment for overpayment is made. If a provider does not submit a dispute of the overpayment, Humana Healthy Horizons adjusts subsequent reimbursements to recoup the overpayment. Providers also can issue overpayment refund checks to Humana Healthy Horizons 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 an member by a third party.

Member billing

State requirements and federal regulations prohibit providers from billing Humana Healthy Horizons members for medically necessary and 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 are, on conviction, fined, imprisoned or both, as defined 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.

Please remember federal government regulations stipulate providers must hold members harmless in the event 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 service not covered by Medicaid. This agreement must be completed prior to providing the service and the member must sign and date the agreement, acknowledging their financial responsibility. The form or type of agreement must specifically state the services or procedures not covered by Medicaid.

Please call the Provider Services Contact Center at **855-223-9868 (TTY: 711)**, for guidance before billing members for services.

Member termination claim processing

From Humana to another plan

In the event of a member's enrollment termination from Humana Healthy Horizons to a different Medicaid plan, Humana Healthy Horizons may submit voided encounters and notify affected providers of adjusted claims via the following process:

- Humana Healthy Horizons determines if claims were paid for dates of service for which the member was later identified as ineligible for Medicaid benefits through Humana Healthy Horizons.

- Humana Healthy Horizons mails a notice to each affected provider of the recoupment process for claim(s) identified in the recoupment letter. The provider has at least 30 business days to respond to the notice.
- Once the 30-business day window expires, Humana Healthy Horizons adjusts subsequent payment(s) for the affected provider(s) if there was no an attempt by the provider(s) to appeal the recoupment of payment or issue a refund check for the affected claims listed in the notice letter. This takes place within 10 business days.
- After the recoupment is processed, either by adjusting subsequent payments to the provider or via a refund check from the provider, it receives a processed date stamp. Once this occurs, a voided encounter for the affected claims is submitted within 10 business days, assuming the original submitted encounter was previously accepted. Please note that if the original encounter was denied or rejected by OHCA, a void does not need to occur.

From another plan to Humana

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

These items are used to support overriding timely filing, if eligible. If a claim exceeds timely filing due to retro-eligibility from another Medicaid plan, the provider has 180 days (six months) from the date of the accepted voided encounter to submit the claim to Humana Healthy Horizons to avoid timely filing denials.

Chapter 12: Member grievances, appeals and state fair hearing requests

The section below is taken from Humana Healthy Horizons' member grievance and appeal procedure, as set forth in the Humana Healthy Horizons in Oklahoma Member Handbook. This information is provided so that providers may assist Humana Healthy Horizons members in this process, should they request it. Please contact your Provider Relations representative with questions you have about this process.

Humana Healthy Horizons representatives who handle member grievances and appeals maintain appropriate records of complaints, including the reason, date and results.

Filing a grievance or an appeal

If the member has questions regarding their plan or an issue, they can call the Member Services Contact Center at **855-223-9868**.

A member may file a grievance when they are dissatisfied with Humana Healthy Horizons or any aspect of their care at any time. A member may file an appeal if the member disagrees with an adverse benefit decision. The member may have someone represent them during the grievance or appeal process, whether a provider or an authorized representative, with written consent. Members also can request assistance filing a grievance or appeal from Member Services.

The grievance or appeal should include the following:

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

If the requestor is not the member, additional documentation, including a Waiver of Liability (WOL) or Appointment of Representative (AOR) form may be required.

Grievance

A member or their authorized representative can file a grievance verbally or in writing. Humana Healthy Horizons acknowledges receipt of member grievances within 10 calendar days. Humana Healthy Horizons resolves the grievance as quickly as the member's health condition requires. Grievances concerning a member's request for disenrollment are resolved within 10 calendar days from the date of receipt. Grievances regarding all other matters are resolved within 30 calendar days from the date Humana Healthy Horizons receives the request. A letter is sent to the member or their authorized representative to provide notice of the grievance outcome.

Appeal

The member may file a written or verbal appeal within 60 calendar days from the date of a notice of adverse benefit decision. Instructions for filing an appeal, along with the mailing address and fax number, are included in the notice. Humana Healthy Horizons acknowledges receipt of appeals within 5 calendar days of receipt. The appeal is resolved as quickly as the member's health condition requires, but no later than 30 calendar days from the date of Humana Healthy Horizons' receipt of the request. Humana Healthy Horizons then mails a letter advising the outcome of the appeal to the member and their authorized representative.

Humana Healthy Horizons may extend this time frame by up to 14 calendar days if more information is needed to make a determination and extending the time frame is beneficial to the member (i.e., receiving the additional information would likely result in approval of the appeal). Humana Healthy Horizons attempts to deliver verbal notice of the need for an extension and deliver written notice within two calendar days of the decision to extend the time frame. If the member disagrees with the extension, the member may file a grievance regarding the extension. The authorized representative requesting the appeal also may ask Humana Healthy Horizons for an extension.

Expedited appeal process

If the member's life, physical or mental health, or ability to attain, maintain or regain maximum function would be at risk following the standard appeal time frame of 30 calendar days, the member or their authorized representative can request a verbal or written expedited appeal. The expedited appeal must be requested within 60 calendar days of the date on the adverse benefit decision notice. Humana Healthy Horizons resolves an expedited appeal within 72 hours of receipt, whether received verbally or in writing.

Humana Healthy Horizons attempts to provide verbal notice of the outcome of the expedited appeal. A letter is also sent, advising the outcome of the expedited appeal to the member and their authorized representative.

Whether received verbally or in writing, if the expedited appeal request does not meet expedited criteria, Humana Healthy Horizons resolves the request within the standard resolution time frame of 30 calendar days.

We may extend the expedited appeal time frame by up to 14 calendar days if more information is needed to make a determination and extending the time frame is beneficial to the member (i.e., receiving the additional information would likely result in approval of the appeal). Humana Healthy Horizons attempts to deliver verbal notice of the need for an extension and provides written notice within two calendar days of the decision to extend the time frame. If the member disagrees with the extension, the member may file a grievance. The authorized representative requesting the appeal also may ask us to take an extension.

Mail a member's grievance or appeal request in writing to the following address:
Humana
Attn: Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax: **800-949-2961**

If you have further questions, please call the Member/Provider Services Contact Center at **855-223-9868**.

Medicaid state fair hearing process

If the appeal decision is not fully in the member's favor, the member may appeal to the Oklahoma Health Care Authority.
Grievance Docket Clerk
P.O. Drawer 18497
Oklahoma City, OK 73154-0497
Fax: **405-530-3444**
Phone: **405-522-7217**
Email: **docketclerk@okhca.org**

Appeals to the external Medicaid state fair hearing process must be filed within 120 calendar days of the date of the internal appeal decision.

Continuation of benefits

While the state fair hearing or appeal is pending, Humana Healthy Horizons continues paying the member's benefits if all the following conditions are met:

- 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.

If the member receives a continuation or reinstatement of their benefits while the appeal or state fair hearing is pending, Humana Healthy Horizons continues the benefits until one of the following occurs:

- The member withdraws the appeal or state fair hearing.
- A state fair hearing officer issues a decision that is adverse to the member.

If the state fair hearing is decided in the member's favor and services are not provided to the member while the state fair hearing is pending, Humana Healthy Horizons approves the services within 72 hours of the date we receive notice of the favorable decision.

Chapter 13: Provider complaint system

If you are not satisfied with Humana's policies and procedures or a decision made by Humana Healthy Horizons that does not impact the provision of services to members, you may file a provider complaint. The provider complaint system consists of two internal steps:

1. **Reconsideration:** The first step in the provider complaint system, a reconsideration represents your initial request for an investigation into a denied claim, Humana Healthy Horizons' policies and procedures, findings of a provider payment integrity (PPI) audit, or the termination of a provider agreement. Most issues are resolved at the reconsideration step.
2. **Formal appeal:** The second step in the process; if a provider disagrees with the outcome of the reconsideration, an additional review known as a formal appeal can be made.

Reconsideration

Providers can submit a reconsideration request via telephone, written correspondence, via Availity Essentials or with their assigned provider relations representative via email or during an onsite visit. If the reconsideration request involves the outcome of a claim, providers have six months from written notification receipt to submit a complaint. For dissatisfaction with policies and procedures, Provider Payment Integrity Audit findings or Provider Contract Agreement Terminations, providers are allowed 15 calendar days to submit a request for reconsideration.

Reconsideration requests are resolved within 20 calendar days of receipt of the request. Once resolved, a resolution letter is sent to the provider within three business days.

A reconsideration request may be filed using any of the following methods:

- Telephone:
  For claims, call the Provider Services Contact Center at **855-223-9868 (TTY: 711)**. For dissatisfaction with policies and procedures, PPI audit findings or provider contract agreement terminations, please contact your Provider Relations representative.
- Online:
  Provider claim reconsiderations of finalized claims may be submitted online via Availity Essentials. To begin, sign in to **Availity.com** and use the Claim Status tool to locate the claim; then select "Dispute Claim." Then, select the request in the Appeals worklist (located under Claims & Payments) to supply needed information and documentation and submit the request to Humana. Statuses and high-level Humana determinations for claim disputes submitted online can be viewed in the Appeals worklist. For training opportunities, visit **Humana.com/ProviderWebinars**.

Providers also can submit claim reconsideration requests in writing via mail by using the following address:
Humana Healthy Horizons in Oklahoma
Reconsideration Request
P.O. Box 14359
Lexington, KY 40512-4359

All other reconsideration requests can be mailed to the following address:
Humana Healthy Horizons in Oklahoma
Reconsideration Request
Oklahoma Tower
210 Park Ave.
P.O. Box 43
Oklahoma City, OK 73102

Reconsiderations can also be submitted to:
Humana email address: **OKMedicaidProviderRelations@humana.com**

Formal appeals

If you are dissatisfied with the determination of the reconsideration request related to policies and procedures, PPI audit findings, or provider contract agreement terminations, you may request a formal appeal. All appeals are reviewed by an independent panel made up of professionals knowledgeable about the policy and the legal and clinical issues involved in

the matter subject to appeal. The panel also includes individuals who were not involved in any previous consideration of the matter. All information and material submitted by the provider that bears directly on an issue involved in the matter are considered in the formal appeal.

You may submit a written formal appeal within 30 calendar days from the date on the determination letter for the reconsideration request. Humana Healthy Horizons reviews and provides a determination within 30 calendar days. The following is the process for filing a formal appeal:

- Providers or their authorized representative have the option to submit a formal appeal following the reconsideration process. The provider must submit all documentation from the reconsideration request when submitting a formal appeal.
- If the appeal is on behalf of a member, written authorization from the member or their legal representative must be submitted, along with all required documents, prior to the start of the process. The appeal is processed under the member's name.
- A resolution letter is mailed within three calendar days from determination of the appeal.

Please note, a provider's request for reconsideration is required before requesting a formal appeal.

Providers can file an appeal in writing to:
Humana Healthy Horizons in Oklahoma
Provider Appeals
210 Park Ave PO Box 43
Oklahoma City, OK 73102
Or via email at **OKProviderRelations@Humana.com**

Administrative Appeal

In the event a provider completes a formal appeal process and remains dissatisfied with Humana Healthy Horizons' determination, they have the option to request an administrative appeal within 30 calendar days from the date of the appeal determination. Providers have the right to be represented by counsel at the administrative appeal. A request should include decisions from all previous reconsiderations and formal appeals. Humana supplies OHCA with all relevant information within 15 days of receiving the administrative appeal request.

Mail Administrative Appeal requests to:
Docket Clerk, OHCA Office of Hearings and Appeals
P.O. Drawer 18497
Oklahoma City, OK 73154-0497

Chapter 14: Provider rights and responsibilities

Provider rights

Healthcare providers that contract with Humana Healthy Horizons to furnish services to Humana Healthy Horizons members are assured the following rights:

- To advise and advocate on behalf of members, including the right to file a grievance or appeal on behalf of a member as their authorized representative
- To be provided, on request, all administrative, financial and medical records related to the delivery of items or services for which state or federal monies are expended, unless otherwise provided by law by Humana, our subcontractors and participating providers. Any audit of a participating pharmacy provider also must comply with the requirements of 59 O.S. § 356.2.
- To review, on request, information submitted to support their credentialing application to the Humana Credentialing department. Humana keeps all submitted information secured and confidential. Access to electronic credentialing information is password protected and limited to staff that require access for business purposes.
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who acts within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification

Provider responsibilities

Providers are required to meet all state and federal participation requirements including, but not limited to, background screening compliance. Contracted providers are monitored on an ongoing basis to ensure continued compliance with participation criteria. Humana Healthy Horizons initiates immediate action if participation criteria are no longer met. Network providers are required to inform Humana Healthy Horizons of changes in status, including but not limited to, being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure or board certification, an event reportable to the National Practitioner Data Bank (NPDB), federal, state or local sanctions, or complaints.

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

- Provide all covered services that are within the normal scope and in accordance with your licenses and/or certifications.
- Possess an NPI to the extent such provider is not an atypical provider, as defined by CMS.
- Meet applicable appointment waiting time standards and after-hours coverage requirements.
- Abide by member rights and responsibilities, per the provider agreement.
- Display notices in public areas of their facility a member's rights to grievances, appeals and state hearings, in accordance with all state requirements.
- Provide physical access, reasonable accommodations and accessible equipment for members with physical or mental disabilities.
- Accommodate interpreters.
- Hold members harmless except for any applicable copayment amounts allowed by OHCA.
- Render emergency services without prior authorization.
- Keep member information confidential.
- Comply with necessary and authorized member communications, movement and/or reassignment.
- Maintain an adequate record system for recording services and all other commonly accepted information elements including, but not limited to, charges, dates and records necessary for evaluation of the quality, appropriateness and timeliness of services performed.
- Maintain all records related to services provided to members for a 10-year period.
- Make all member medical records or other service records available for any quality reviews conducted by Humana, OHCA or its designated agent(s) during and after the term of the Provider Agreement.
- Furnish and maintain member health records using professional standards.
- Connect to the state Health Information Exchange (HIE) for the purpose of bi-directional health data exchange; if you do not have a certified EHR, use the state HIE provider portal to query patient data for enhanced patient care.

- Sign a participation agreement with the state HIE and sign up for direct secure messaging services and portal access if you do not already have EHR.
- Sign a participation agreement with the state HIE within one month of contract signing.
- Allow authorized representatives of OHCA and other state or federal agencies reasonable access to facilities and records for audit purposes during and after the term of the Provider Agreement.
- Release to Humana Healthy Horizons any information necessary to monitor provider performance on an ongoing and periodic basis.
- Send electronic patient even notifications of a member's admission, discharge and/or transfer to the state HIE (applicable to network hospitals, long-term care facilities and emergency departments).
- Submit all reports, clinical information and encounter data required by Humana Healthy Horizons and OHCA in a timely manner.
- Participate and cooperate in internal and external quality management or quality improvement activities.
- Follow the standards for medical necessity as required under the contract and regulatory rules.
- Complete all required annual trainings.
- Implement and provide a tobacco-free campus, in accordance with the standards of the Tobacco Free policy of the State of Oklahoma 63 O. S. § 1-1523 and Executive Order 2013-43. Providers must make an effort to communicate the tobacco-free campus in signage and other communications associated with their organization.

PCP responsibilities

In addition to the provider responsibilities in the previous section of this manual, PCPs also have the following responsibilities:

- Deliver primary care and follow-up care services.
- Utilize and practice evidence-based medicine and clinical decision supports.
- Screen members for behavioral health disorders and conditions.
- Make referrals for specialty care, behavioral health services and other covered services and, when applicable, work with Humana Healthy Horizons to allow members direct access to a specialist as appropriate for a member's condition and identified needs.
- Ensure there is a process to follow up on referrals for members made to specialists.
- Maintain a current medical record for the member.
- Use health information technology to support care delivery.
- Provide care coordination in accordance with the member's care plan, as applicable based on the Humana Healthy Horizons' risk stratification level framework and in cooperation with the member's care manager.
- Ensure coordination and continuity of care with providers including, but not limited to, specialists and behavioral health providers.
- Engage participation of the member and the member's family, authorized representative or personal support, when appropriate, in healthcare decision-making, feedback and care plan development.
- Provide access to medical care 24 hours a day, seven days a week, either directly or through coverage arrangements made with other providers, clinics and/or local hospitals.
- Offer enhanced access to care, including extended office hours outside normal business hours, and facilitate use of open scheduling and same-day appointments where possible.
- Participate in continuous quality improvement and voluntary performance measures established by Humana Healthy Horizons and/or OHCA.

Behavioral health provider responsibilities

In addition to provider responsibilities listed in the previous sections of this manual, behavioral health providers also have the following responsibilities:

- Schedule a member receiving inpatient psychiatric services for outpatient follow-up care prior to discharge; outpatient treatment must occur within seven calendar days from the date of discharge.
- Complete the Oklahoma DMH and Substance Abuse Services (ODMHSAS) Customer Data Core form, located on **odmhsas.org/picis/CDCPAForms/arc_CDCPA_Forms.htm**, as a condition of payment for services provided.
- Provide treatment to pregnant members who are intravenous drug users and all other pregnant substance users within 24 hours of assessment.

Adverse actions

Humana Healthy Horizons complies with the Federal Health Care Quality Improvement Act and has an active peer review committee. Humana Healthy Horizons reserves the right to immediately suspend or summarily dismiss, pending investigation, the participation status of a network provider who, in the opinion of the Humana senior medical director or peer review committee, engages in behavior or practices in a manner that poses a significant risk to the health, welfare or safety of our members. Participating providers who are subject to an adverse action that affects their status for more than 30 days are offered a fair hearing opportunity with an additional physician panel review of the adverse action.

Advance directives

PCPs have the responsibility to discuss advance medical directives with Humana Healthy Horizons-covered patients who are 18 or older and who are of sound mind at the first medical appointment, consistent with OAC 317:30-3-13(a)(5). The discussion should 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 the member was given written information concerning the member's rights regarding advance directives (i.e., written instructions for living will or power of attorney), including whether the member has executed an advance directive. (42 CFR 438.3(j)(3)). Neither the managed care plan, nor any of its providers require, as a condition of treatment, the member to execute or waive an advance directive, as per 42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5).

A member may revoke his or her advance directive at any time, without regard to his or her medical or mental health, in accordance with 63 O.S. § 3101.6 and the following:

- If the member is pregnant and the provider is aware, the pregnant patient is given life-sustaining treatment; except when the patient specifically authorized treatment to be withheld during pregnancy, pursuant to 63 O.S. § 3101.8.
- If a provider is unable or unwilling to provide care as per the advance directive (63 O.S. § 3101.9), Humana Healthy Horizons processes the information. The provider then transfers care of the member to another provider to comply with medical decisions of the member. The original provider must comply with the member's advance directive during the transfer process if the member may die unless the provider is physically or legally unable to provide without thereby denying the same treatment to another patient.
- An advance directive from another state is valid to the extent that it does not exceed authorizations allowed under Oklahoma laws. It must be executed by the individual to which the directive applies, and it must specifically authorize withholding/withdrawal of artificial nutrition/hydration and be signed, pursuant to 63 O.S. § 3101.14.

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 if the provider serves only Medicaid managed care members.
Participating PCPs and medical/behavioral health specialists are required to offer adequate accessibility for healthcare 24 hours a day, seven days a week when medically necessary. An after-hours PCP telephone number must be available to members. Voicemail is not permitted.

Humana's provider network must meet OHCA's time and distance standards. Members should have access to care for PCP services and referrals to specialists for medical and behavioral health services available on a timely basis:

Provider type	Measure	Standard
Distance		
Adult and Pediatic PCP	Urban distance	Within ten miles of a Humana member's residence
Adult and Pediatric PCP	Rural distance	Within 30 miles of a Humana member's residence

Provider type	Measure	Standard
Appointment time		
Adult and Pediatric PCP	• Not to exceed 30 days from date of the Humana member's request for routine appointment • Within 72 hours for non-urgent sick visits • Within 24 hours for urgent care • Each PCP must allow for at least some same-day appointments to meet acute care needs.	

Provider type	Measure	Standard
Distance		
OB-GYN	Urban distance	Within 10 miles of a Humana member's residence
OB-GYN	Rural distance	Within 45 miles of a Humana member's residence
Appointment time		
OB-GYN	• Not to exceed 30 days from date of the Humana member's request for routine appointment • Within 72 hours for non-urgent sick visits • Within 24 hours for urgent care Maternity care: • First trimester – Not to exceed 14 calendar days • Second trimester – Not to exceed seven calendar days • Third trimester – Not to exceed three business days	

Provider type	Measure	Standard
Distance		
Adult specialty **Pediatric specialty**	Urban distance	Within 15 miles of a Humana member's residence
Adult specialty **Pediatric specialty**	Rural distance	Within 60 miles of a Humana member's residence
Appointment time		
Adult specialty **Pediatric specialty**	• Not to exceed 60 days from date of the Humana member's request for routine appointment • Within 24 hours for urgent care	

Provider type	Measure	Standard
Distance		
• **Adult and pediatric mental health** • **Adult and pediatric substance use**	Urban distance	Within 10 miles of a Humana member's residence for outpatient visits Within 60 miles of a Humana member's residence for all other treatment settings
• **Adult and pediatric mental health** • **Adult and pediatric substance use**	Rural distance	Within 30 miles of a Humana member's residence for outpatient visits Within 90 miles of a Humana member's residence for all other treatment settings

Provider type	Measure	Standard
Appointment time		
• **Adult and pediatric mental health** • **Adult and pediatric substance use**	Not to exceed 30 days from date of the Humana member's request for routine appointment Within 7 days of residential care and hospitalization Within 24 hours for urgent care	
Provider type	**Measure**	**Standard**
Distance		
Pharmacies	Urban service area, meaning a five-digit ZIP code in which the population density is greater than 3,000 individuals per square mile	At least 90% of Humana members reside within two miles of a retail pharmacy participating in the PBM's retail pharmacy network
	Suburban service area, meaning a five-digit ZIP code in which the population density is between 1,000 and 3,000 individuals per square mile	At least 90% of Humana members reside within five miles of a retail pharmacy in the PBM's retail pharmacy network
	Rural service area, meaning a five-digit ZIP code in which the population density is less than 1,000 individuals per square mile	At least 70% of Humana members reside within 15 miles of a retail pharmacy in the PBM's retail pharmacy network
Mail order pharmacy	Not applicable	Not applicable
Appointment time		
Pharmacies	Not applicable	
Provider type	**Measure**	**Standard**
Distance		
Essential community providers	Urban distance	Within 10 miles of a Humana member's residence
Essential community providers	Rural distance	Within 45 miles of a Humana member's residence
Appointment time		
Essential community providers	Not specified	
Provider type	**Measure**	**Standard**
Distance		
Hospitals	Urban distance	Within 10 miles of a Humana member's residence
Hospitals	Rural distance	Within 45 miles of a Humana member's residence
Appointment time		
Hospitals	Not specified	

Personally identifiable information and protected health Information

In the day-to-day business of patient treatment, payment and healthcare operations, Humana Healthy Horizons and our providers routinely handle large amounts of personally identifiable information (PII). To reduce the chance of exposing the PII of our members to identity theft and other threats, Humana Healthy Horizons uses industry best practices and standards to guide proper protection, storage and transmission of PII while conducting normal business. As a provider, you should be taking measures to secure your patients' data.

Healthcare providers 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 in your provider office 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 potentially contain PHI or PII.

Marketing

In accordance with Section 1.12.7.7 of the contract between Humana Healthy Horizons and OHCA, the following permissible activities are applicable to Humana, its agents, subcontractors and providers:

- The contractor may partake in forms of social media advertising (e.g., X [formerly Twitter], Facebook, Instagram) after securing OHCA's prior written approval.
- The contractor may purchase advertisement banners on social media outlets. The content of such advertisements must be approved by OHCA prior to distribution, after securing OHCA's prior written approval.
- The contractor may post Medicaid events on social media sources. The content of such posts must be approved by OHCA prior to posting.
- Humana may post general non-advertising information regarding the contractor's activities. The content of such posts does not require OHCA's prior approval.
- Any member complaints received through social media sources must be processed and resolved through the general complaint intake system

The following prohibitions are applicable to the contractor, its agents, subcontractors and providers:

- Posting or sending any protected private information on social media sources
- Advertising on social media platforms that entail direct communication with prospective members that include, but are not limited to:
  - Snapchat
  - Skype
  - WhatsApp
  - Facebook Messenger
  - MeetUp
  - Viber
- Responding to comments on social media posts from prospective members except when to provide general response, such as the contractor phone number, links to the contractor web site or the enrollment broker phone number
- Partaking in individual communication on social media outlets
- Requesting followers or adding individuals as friends (e.g., friends on Facebook, followers on Instagram or X [formerly Twitter], etc.)
- Tagging individuals on social media sources

Member privacy

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

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

Missed appointments

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

Oklahoma Medicaid provider enrollment requirements

All providers must be eligible for participation in the Medicaid program. If you are currently suspended or involuntarily terminated from the Oklahoma 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 Oklahoma Medicaid provider number in accordance with the guidelines of OHCA. You 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 Oklahoma Medicaid provider status using data provided by OHCA. Humana Healthy Horizons may deny reimbursement for covered services if we determine you do not have a current Oklahoma Medicaid provider number when we adjudicate 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. Notification of changes should be submitted at least 30 days prior to the effective date of the change to avoid claim and directory discrepancies. Examples of changes that require notification include:

- TIN changes
- New providers added to group
- Providers leaving group
- Changes to service address, i.e., new location, phone or fax numbers*
- Access to public transportation
- Standard hours of operation and after hours
- Billing address updates
- Credentialing updates
- Panel status
- Gender
- Languages spoken in office

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

Notification of changes should be emailed to:

- Medical providers: **OKMedicaidProviderRelations@humana.com**
- Behavioral health providers: **OKBHMedicaid@humana.com**

* Data displayed within the online directory will reflect the most current information reported to OHCA.

Health, safety and welfare

By law, Psychiatric Residential Treatment Facility (PTRF) providers must immediately report suspected abuse, neglect or exploitation risks to the appropriate state agency and the member's Humana Integrated Care Team care manager.

A report of suspected abuse, neglect or exploitation risk can include, but is not limited to:

- **Abuse** – Non-accidental infliction of physical and/or emotional harm
- **Physical abuse** – Causing the infliction of physical pain or injury to a person
- **Sexual abuse** – Includes unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity; touching, fondling, sexual threats, sexually inappropriate remarks or any other sexual activity when the person is unable to understand, unwilling to consent, threatened or physically forced to engage in sexual activity
- **Psychological abuse** – Includes, but is not limited to, name calling, intimidation, yelling and swearing; may also include ridicule, coercion and threats.
- **Emotional abuse** – Verbal assaults, threats of maltreatment, harassment or intimidation intended to compel the person to engage in conduct from which he or she wishes and has a right to abstain, or to refrain from conduct in which the person wishes and has a right to engage
- **Neglect** – Repeated conduct or a single incident of carelessness which results or could reasonably be expected to result in serious physical or psychological/emotional injury or substantial risk of death (this includes self-neglect and passive neglect).
- **Exploitation** – Illegal use of assets or resources of an adult with disabilities; including, but not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion or in any manner contrary to law.

Individuals who report these situations receive immunity from civil and criminal liability, unless the report was made in bad faith or with malicious intent. Unless a court orders the reporter's identity revealed, he or she also receives identity protection.

Additional information and training on this topic is included in Humana's required annual health, safety and welfare education compliance training.

Critical incident reporting

When a member is in the care of a behavioral health inpatient, residential or crisis stabilization unit, critical incidents can include, but are not limited to, the following, in accordance with OAC 317:30- 5-95.39:

- Suicide
- Non-suicide death
- Death—cause unknown
- Homicide
- Homicide attempt with significant medical intervention
- Suicide attempt with significant medical intervention
- Allegation of physical, sexual or verbal abuse or neglect
- Accidental injury with significant medical intervention
- Use of restraints/seclusion (isolation)
- Away without leave (AWOL) or absence from a mental health facility without permission
- Treatment complications (i.e., medication errors and adverse medication reaction) requiring significant medical intervention

Psychiatric Residential Treatment Facility (PTRF) providers are required to report adverse or critical incidents to Humana Healthy Horizons, the OHCA Behavioral Health Unit and Oklahoma Department of Human Services (DHS) by phone no later than 5 p.m. on the business day following a serious occurrence. The report should disclose, at a minimum, the name of the member involved, a description of the occurrence, and the name, street address and telephone number of the facility, in accordance with OAC 317:30-5-95.39 In the case of a minor, the provider also must notify the member's parent(s) or legal guardian(s) as soon as possible, and no later than 24 hours after the serious occurrence.

Providers can report incidents via the following phone numbers:
Humana Healthy Horizons in Oklahoma Provider Services Contact Center: **855-223-9868**
OHCA Behavioral Health Unit: **800-522-9054**
Oklahoma Department of Human Services: **405-522-5050**

PTRF providers must immediately (not to exceed 24 hours) take steps to prevent further harm to all members and respond to any emergency needs of members. PTRF providers must conduct an internal critical incident investigation and submit a report on the investigation as soon as possible, based on the severity of the critical incident, and no later than three days from the serious occurrence, to Humana Healthy Horizons, the OHCA Behavioral Health Unit, DHS, and the member's parent or legal guardian, in accordance with the time frames established by OAC 317:30-5-95.39(c). Humana Healthy Horizons reviews the PTRF's report and follows up with the PTRF provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable time frames.

Reporting abuse, neglect and exploitation

Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, Section 1-2-101 of Title 10A of the Oklahoma Statutes and 43A O.S. 10-104. Any person suspecting child abuse or neglect must immediately report it to the Oklahoma DHS hotline by calling **800-522-3511**. Any person suspecting abuse, neglect or exploitation of a vulnerable adult must immediately report it to the local DHS County Office, municipal or county law enforcement authorities or, if the report occurs after normal business hours, the Oklahoma DHS hotline. Healthcare professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity must promptly make a report to the nearest law enforcement agency, per 22 O.S. 58.

Americans with Disabilities Act

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

Providers are required to comply with all ADA requirements, including:

- Use of waiting room and exam room furniture and accessible routes to and through rooms that meet needs of all members, including those with physical and nonphysical disabilities
- Use of clear signage throughout provider offices
- Provision of adequate handicapped parking

Humana's minimum provider agreement requirements include:

- Providers must provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities, in accordance with 42 C.F.R. § 438.206(c)(3)

Resources available to help providers comply with ADA requirements

Additional educational resources are available on our **Accessibility Resources on Humana.com** to help contracted healthcare providers learn more about ADA requirements and best practices for maintaining accessible and inclusive practices, including tips and suggestions for providing inclusive and member-centric care to those with intellectual disabilities, speech impairments or difficulties, and more.

Chapter 15: Provider training and education

Provider education objectives

Our overall goal for provider education and engagement is to ensure Humana Healthy Horizons partners closely with you and your business, and delivers a best-in-class provider experience. Humana Healthy Horizons believes the key to successfully engaging providers is to develop a partnership working toward a common goal of delivering quality care to our members. To achieve this goal, we implement a robust provider engagement strategy and support structure to ensure you have the educational tools and resources you need. We focus on the following objectives:

- Transition you successfully to the new Medicaid managed care model
- Ensure you understand your rights and responsibilities when participating within the Humana network
- Provide clear explanation of Humana program policies to ensure compliance
- Provide useful tools, resources and educational materials on how to do business with Humana, including navigating Humana's systems and care management model
- Demonstrate partnership opportunities to deliver high quality and evidence-based clinical care that drive value and performance

Required compliance-based training programs

Providers must adhere to all Humana-identified compliance-based training programs and requirements outlined in Humana's policies on compliance and standards of conduct and submit an attestation annually to certify adherence to training requirements. This includes agreement and assurance that all affiliated participating providers, along with supporting healthcare providers and staff who interact with members, receive training on identified compliance material. Humana requires other training and education as required or requested by OHCA or any other state or federal agency.

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

Contracted providers must complete the following trainings annually, as required by Section 6032 of the Federal Deficit Reduction Act of 2005, Humana's contract with OHCA and/or Humana policies:

- Humana Healthy Horizons in Oklahoma new provider orientation — Humana reaches out to newly contracted providers to complete a new provider orientation training (either via webinar or in-person) within 30 days of contract effective date.
- Cultural humility
- **Abuse Neglect and Exploitation**
- Combating fraud, waste and abuse
- **Ethics Everyday training**

Humana requires your employees receive fraud, waste and abuse (FWA) training. Your organization can create and train using its own FWA content, or it can use content provided on CMS's website. Humana reserves the right to request evidence at any time of an organization's FWA training occurred, that the organization was trained using an appropriate training module, and that the organization documented processes for tracking training compliance. For more information on fraud, waste and abuse, please see the fraud, waste and abuse policy chapter.

Compliance requirements should be completed within 30 days of notification.

Completing your compliance training and attestation online

Providers can access compliance training online via Availity Essentials using the following steps:

- Sign in to Availity Essentials at **Availity.com**.
- Select Payer Spaces – Humana.
- Select the Resources tab.
- Select Humana Compliance Events.
- Select "I agree" to the pop-up to indicate you are leaving Availity's website.
- If a security warning pops up indicating that you are navigating to **https://sso2.archer.rsa.com**, choose Yes to proceed. You will be entering Humana's secured compliance portal.
  - If directed to select a Humana Partner option, please select Availity SSO. You also can select "Remember my selection" to bypass the question in the future.

- Follow the on-screen instructions to add, review and accept the compliance events.
- Select “Actions and Complete,” and then “Save and Close.”
- All applicable events show a status of “Review Complete.”

It may take a few hours before Availity Essentials lists your training module and attestation as “competed” in your training history.

If your organization is unable to register at Availity Essentials, please visit **Humana’s Availity Essentials Help document**.

Please note: An attestation at the organization level must be submitted annually to Humana to certify your organization has a plan in place to comply with and conduct training on Medicaid-required topics.

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

- Must still complete the training
- Does not need to submit an attestation to Humana

Chapter 16: Member rights and responsibilities

Member rights

Humana Healthy Horizons members have the right to:

- Receive information on the Humana Healthy Horizons program
- Be treated with respect and with due consideration for their dignity and privacy
- Receive information on available treatment options and alternatives, in a way the member understands
- Participate in decisions regarding their healthcare, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Request and receive a copy of their medical records and to request they be amended or corrected
- Obtain available and accessible healthcare services covered by Humana Healthy Horizons
- Request a provider with the same race, ethnicity, and language as the member if there is a provider available in the network

Member responsibilities

Humana Healthy Horizons members have the following responsibilities:

- Check OHCA/Humana Healthy Horizons information, correct inaccuracies and allow government agencies, employers and providers to release records to OHCA/Humana Healthy Horizons
- Notify OHCA or Humana Healthy Horizons within 10 days if there are changes in income, the number of people living in the home, address or mailbox changes, or health plan changes.
- Transfer, assign and authorize to OHCA all claims a member may have against health insurance, liability insurance companies or other third parties. This includes payments for medical services made by OHCA for any dependents.
- Work on requests for assistance from the Office of Child Support Services
- Allow SoonerCare to collect payments from anyone who is required to pay for medical care.
- Share necessary medical information with any insurance company, person or entity who is responsible for paying the bill.
- Inspect any medical records to see if claims for services can be paid.
- Obtain permission for Oklahoma Human Services or OHCA to make payment or overpayment decisions.
- Keep an identification card and know their Social Security number to receive healthcare services or prescriptions.
- Confirm that any care received is covered.
- Understand how and when to request NEMT services.
- Cost sharing.
- Ensure all information provided to OHCA or Humana Healthy Horizons is complete and true on penalty of fraud or perjury.

Chapter 17: Cultural competency

Understanding cultural competency

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

Cultural competency in healthcare describes a focus on understanding how a population's diverse values, beliefs and behaviors influence the way in which it seeks healthcare. These efforts include tailoring delivery to meet patients' social, cultural and linguistic needs. Services should be delivered in a culturally aware manner to all Medicaid managed care members—including those with limited English proficiency and diverse cultural and ethnic backgrounds. By doing so, Humana Healthy Horizons and contracted healthcare providers increase understanding, appreciation, acceptance and respect for cultural differences, and develop an understanding of how these differences influence relationships with Medicaid managed care members (as required by 42 CFR §438.206).

How to provide culturally competent care

Participating providers are expected to provide services in a culturally competent manner including, but not limited to, removing all language barriers to service and accommodating the special needs of the ethnic, cultural and social circumstances of the patient. Participating providers also must meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act and the Rehabilitation Act of 1973.

Benefits of culturally competent care

Cultural competence in a hospital or care system produces numerous benefits for the organization, patients and community. Organizations that are culturally competent have improved health outcomes, increased respect and mutual understanding from patients, and increased participation from the local community. They also may have lower healthcare costs and fewer care disparities.

Cultural factors influence patients' health beliefs, behaviors and responses to medical issues. This section provides guidance for how to consider cultural differences as you build effective relationships with your patients during shared decision making.

Recommendations when interacting with patients across cultures and underserved communities

- Keep an open mind. Remember each patient has a unique set of beliefs and values, and they may not share yours.
- Ask patients about their beliefs regarding their health condition. (e.g., "What do you think caused the problem? What do you fear most about the sickness? Why do you think it started when it did?") This information allows you to make the most of your interactions during shared decision making. Recognize and understand the meaning or value of health prevention, intervention and treatment may vary greatly among cultures, especially for behavioral health.
- In addition to completing the required Humana Cultural Competency training, attend cultural competence training at your organization or through a continuing education program.
- Be aware of your own culture and how that may affect how you communicate with your patients.
- Reach out to cultural brokers to learn more about the differences and similarities between cultures. Cultural brokers might include healthcare and social service workers and cultural group leaders. They can tell you how to better address patients' health via culturally appropriate strategies, understand beliefs about health and lower barriers to communication. Ask them to suggest resources you can use to learn more about your patients' cultures.
- Know what you do not know. You won't be able to learn about every aspect of every patient's culture. Don't be afraid to let your patients know that you are unfamiliar with their culture. Invite them to explain what is important to them and how getting and staying well works in their community.

Keep in mind that culture is not homogenous. There is great diversity among individuals—even in the smallest cultural group. Cultures also change over time; what might help now may not help in the future.

Providing culturally appropriate decision aids

Ask your patients about their learning preferences to help better present information during shared decision making. Find out if your patients prefer for you to offer materials in print, video or audio format. Ask your patients if they want you to explain by talking, using a model, making a drawing or demonstrating how to do something. You may find your patients want you to present information in a variety of ways.

Make sure multimedia decision aids (e.g., videos, DVDs, CDs, audiotapes), other health resources for treatment and other intervention materials reflect the cultures of the patients you serve.

When possible, offer decision aids, treatment summaries and educational materials that have culturally relevant descriptions of risks and benefits of treatment options. The best decision aids meet cultural and health literacy or plain language standards.

Implicit bias

Implicit bias refers to the unconscious prejudice individuals might feel about another thing, group or person. In healthcare, implicit bias can shape the way medical providers interact with patients. Because everyone is susceptible to implicit bias, even clinicians, these unconscious preconceptions naturally seep into patient–provider communication.

Implicit bias can affect the patient experience. By damaging patient–provider interactions, it can adversely impact health outcomes. Patients often are able to pick up on a provider's implicit bias and may report a poor experience as a result. A patient who picks up on a provider's implicit bias may feel less inclined to engage deeply with care.

Eliminating implicit bias is a challenging task as most people are not aware of their own implicit biases. But a strong education campaign can be a good first step to help healthcare providers discern their own biases. The process of identifying and acknowledging implicit bias in healthcare is only in its infancy. But it's an important step towards ending racial health disparities and working toward health equity.

Actions you can take to combat implicit bias include:

- Having a basic understanding of the cultures from which your patients come
- Avoiding stereotyping your patients; individuate them
- Understanding and respecting the magnitude of unconscious bias
- Recognizing situations that magnify stereotyping and bias
- Knowing the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, found at the **U.S. Department of Health and Human Services' website**
- Performing the "teach-back" method (e.g., the National Patient Safety Foundation's "Ask Me 3"® educational program)
- Practicing evidence-based medicine
- Using techniques to de-bias patient care, which includes training, intergroup contact, perspective-taking, emotional expression and counter-stereotypical exemplars

Health equity

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this state requires focused and ongoing societal efforts to address historical and contemporary injustices; to overcome economic, social and other obstacles to health and healthcare; and to eliminate preventable health disparities. Differences in access, treatment and outcomes between individuals and across populations that are systemic, avoidable, predictable and unjust are particularly problematic. These types of differences are often referred to as inequities or disparities. Inequities are the worst type of unwanted variation in a system—variation linked to the complicated history and reality of racism, classism, sexism, ableism, ageism and other forms of oppression. Healthcare providers have an outsized role to play in healthcare systems and communities to remediate inequities. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

Health literacy

The U.S. Department of Health and Human Services (HHS) addresses both personal health literacy and organizational health literacy in their new Healthy People 2030 definitions. More information on HHS' efforts to improve health literacy can be found at the **National Institutes of Health website**.

Health literacy involves both:

- Personal health literacy: degree to which an individual can find, understand and use information and services to inform health-related decisions and actions for themselves and others
- Organizational health literacy: degree to which organizations equitably enable individuals to find, understand and use information and services to inform health-related decisions and actions for themselves and others

Health literacy:

- Emphasizes people's ability to use health information rather than just understand it
- Focuses on the ability to make "well-informed" decisions rather than "appropriate" ones
- Incorporates a public health perspective
- Acknowledges organizations have a responsibility to address health literacy

Health literacy incorporates a range of abilities: reading, comprehending and analyzing information; decoding instructions, symbols, charts and diagrams; weighing risks and benefits; and, ultimately, making decisions and taking an action.

Key health literacy research findings:

- We must not blame an individual for not understanding information that has not been made clear.
- Everyone, no matter how educated, is at risk for misunderstanding health information if the topic is emotionally charged or complex.
- In almost all cases, physicians and other health professionals try to, and believe they are, communicating accurate information.
- In some cases, patients believe they understood directions but may be embarrassed to ask questions to confirm their understanding.
- Healthcare organizations and their systems and procedures have a significant role to play in ensuring understanding in the healthcare setting.
- It is increasingly difficult for people to separate evidence-based information, especially online, from misleading ads and gimmicks.
- The communication of "risk" in an effective and fair way continues to be a challenge for both the provider and the patient.
- There are additional challenges in understanding how to select insurance plans and benefits, especially for those who have not previously been insured.

Humana Healthy Horizons-related programs and initiatives

Humana Healthy Horizons offers several initiatives to deliver services to all members regardless of ethnicity, socioeconomic status, culture or primary language. These include:

- Collecting race and ethnicity data and analysis to identify variations in the quality of care delivered to different groups and developing strategies to improve care delivery
- Training internal staff on cultural humility, health equity, health literacy and implicit bias
- Assigning care managers to members based on their language needs, cultural compatibility and gender preference, to better align with the individual's choice

Chapter 18: Quality improvement

Overview

Humana's Quality Assessment and Performance Improvement (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 objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable medical and behavioral healthcare and services. Strategies are identified and activities implemented in response to findings. Using a continuous quality improvement methodology, the 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 include monitoring clinical indicators or outcomes, quality-of-care complaints, utilization metrics, quality studies, HEDIS measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results and medical record audits. These activities are included in the QAPI workplan and its annual evaluation. The quality improvement committee (QIC) is delegated by Humana's internal board of directors to monitor and evaluate the results of program initiatives and to implement corrective action when the results are less than desired or when areas that need improvement are identified. The QIC is accountable to Humana 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 member and provider needs and requests
- Monitoring coordination and integration of member care across provider sites
- Monitoring, evaluating and improving the quality and appropriateness of care and service delivery to members through peer review, performance improvement projects (PIPs), medical/case record audits, performance measures, surveys and related activities
- Providing a comprehensive strategy for population health management that addresses member needs across the continuum of care
- Providing mechanisms to assess the quality and appropriateness of care furnished to members with special healthcare needs
- Providing mechanisms to detect underutilization and overutilization
- Providing programs and initiatives to support members with complex needs and multiple chronic conditions in achieving optimal health outcomes.
- Guiding members to achieve optimal health by providing tools that help them understand their healthcare options and take control of their health needs
- Monitoring and promoting the safety of clinical care and service
- Adopting reimbursement models that incentivize the delivery of high-quality care
- Promoting better communication between departments to improve service and satisfaction to members, practitioners, providers and associates
- Promoting improved clinician experience for physicians and all clinicians to promote member safety, provider satisfaction and provider retention
- Publicizing findings to appropriate staff and departments

Activities of the QAPI program include developing clinical practice guidelines, performing medical record documentation reviews, analyzing HEDIS report results, assessing member satisfaction, and requesting external quality reviews and provider profiling.

Performance standards

Clinical practice guidelines, medical record standards, quality and performance metrics including HEDIS and CAHPS, and other measures enable Humana Healthy Horizons to review data and trends and identify barriers and potential opportunities. This data is reviewed in QIC, and recommendations and initiatives are discussed and operationalized on the recommendations of the committee.

Clinical practice guidelines

These protocols incorporate evidence-based medical and behavioral health guidelines from recognized sources, including professional medical associations, voluntary health organizations and National Institutes of Health (NIH) centers. The protocols can inform your decisions regarding appropriate care for specific clinical circumstances. We strongly encourage providers to review and consider these guidelines. Providers ultimately remain responsible for determining the applicable treatment for every individual.

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

- Provider manual updates
- Provider newsletters
- Provider website

You also can obtain preventive health and clinical practice guidelines through your Provider Relations representative. Clinical practice guidelines also are available on **Clinical Practice Guidelines for Healthcare Providers - Humana**.

Once sufficient claims data is available, the Humana Healthy Horizons in Oklahoma QIC reviews data and trends related to clinical practice guidelines to identify outliers and opportunities for improvement.

Medical record documentation reviews

Humana Healthy Horizons established medical record standards in accordance with OHCA requirements. Records must be maintained for a minimum of 10 years from the last date of entry. For minors, records must be maintained during the period of minority plus a minimum of 10 years after the age of majority (19 years old).

The quality department conducts medical record documentation reviews (MRDRs) on a regular basis. These reviews monitor compliance with medical record standards. Good medical record keeping promotes quality of care delivered to members of Humana Healthy Horizons. The quality department reviews randomly selected records, per contract requirements. The threshold score required for a provider to pass MRDR is 85%, with a goal of at least 90%. The medical record elements include:

- **Patient identification:** Each page in the medical record must contain the patient's name or Medicaid identification number. Records for members should include the members' identifying information, including name, members' identification number, date of birth, gender, and parent or legal guardianship (if applicable).
- **Provider identification:** Identification of the author must be included for all entries, including dictation, and the author should authenticate each entry. Authentication may include signatures or initials, thereby verifying the report is complete and accurate.
- **Entry date:** All entries must be dated.
- **Legibility:** The medical record must be legible to someone other than the writer.
- **Allergies:** Allergies or no known allergies (NKA) must be documented in a uniform location on the medical record. Medication and other adverse reactions must be listed if present.
- **Past medical history:** For patients seen three or more times, past 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.
- **Physical exam (complete):** All body systems should be reviewed within two years of the first clinical encounter, including head, eyes, ears, nose and throat (HEENT), teeth, neck, heart, lungs, neurological, and musculoskeletal. Height, weight, blood pressure and temperature must be documented on the initial visit.
- **History and physical:** Subjective and objective information should be obtained and noted regarding the presenting complaints.
- **Working diagnosis:** The working diagnosis should be consistent with findings (i.e., the provider's medical impression).

- **Plan/treatment:** Documentation of plan of action and treatment should be consistent with diagnoses. In addition, all entries must include the disposition of the patient, recommendations made, instructions to the patient, health education provided, evidence of a follow-up visit and the outcome of services.
- **Records** (e.g., consultation, discharge summaries and ER reports): Reports should be filed in the medical record and initialed by the PCP, thereby signifying review. Past medical records and hospital records (e.g., operative and pathology reports, admission and discharge summaries, consultations and ER reports) should be filed in the medical record.
- **Referrals** (e.g., consultation, therapy): Referrals should be filed in the medical record. Referrals should include follow-up and outcome.
- **Consent forms:** Record should include signed and dated consent forms (as applicable).
- **X-ray/lab/imaging:** Record should show documentation of lab, X-ray, imaging or other studies ordered. Results should be filed in the medical record and initialed by the PCP, 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 positive or negative results.
- **Smoking:** For patients seen three or more times, a notation concerning tobacco use must be present.
- **Alcohol:** For patients seen three or more times, a notation concerning alcohol use must be present.
- **Substance use:** For patients seen three or more times, a notation concerning substance use must be present.
- **Immunization record:** A current record of immunizations should appear in the patient chart.
- **Advance directives:** For patients 21 and older only, there should be evidence the patient was asked if he or she has 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.
- **Prescribed medications:** All current medications, including dose and date of initial prescription or refills, should be present in the medical record.
- **Primary language:** Use of the patient's primary language should be documented along with any communication assistance provided.

HEDIS and other performance measures

HEDIS is a tool used by more than 90% of United States health plans to measure performance on important dimensions of care and service. HEDIS includes care coordination measures for members transitioning from a hospital or emergency department to home for which hospitals and providers have additional responsibilities. Humana Healthy Horizons may conduct medical record reviews to validate HEDIS measures. In addition to medical record reviews, information for HEDIS is gathered administratively via claims, encounters and submitted supplemental data.

There are two primary routes for supplemental data:

- Nonstandard supplemental data involves directly submitted, scanned images (e.g., PDF documents) of completed attestation forms and medical records.
- Nonstandard data also can be accepted electronically via a proprietary electronic attestation form (EAF) or practitioner assessment form (PAF). Submitted nonstandard supplemental data is subject to audit by a team of nurse reviewers before ending a HEDIS improvement opportunity.
- Standard supplemental data flows directly from one electronic database (e.g., population health system, EMR) to another without manual interpretation. Therefore, standard supplemental data is exempt from audit consideration. Standard supplemental data can be accepted via HEDIS-specific custom reports extracted directly from the provider's EMR or population health tool and submitted to Humana Healthy Horizons via either secure email or 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.

In addition to HEDIS measures, Humana Healthy Horizons also reviews other performance measures in accordance with CMS child and adult core sets and other state-specific performance measures.

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 are evaluated. The results are compared to Humana Healthy Horizons' performance goals, and improvement action plans are developed to address any areas in which the standard is not met.

External quality reviews

Humana Healthy Horizons undergoes an annual external quality review (EQR) of the quality, timeliness and access to the services covered under the contract. OHCA retains the services of an external quality review organization (EQRO) to conduct the EQR. Humana Healthy Horizons cooperates fully with the EQRO and demonstrates to the EQRO our compliance with managed care regulations and quality standards. As part of the EQR, Humana Healthy Horizons may request member medical records from you.

Provider profiling

Humana Healthy Horizons conducts PCP and other participating provider profiling activities to assess provider effectiveness and efficiency. This methodology is developed as part of the QAPI program and reviewed annually to identify and review the measures used for profiling providers. Provider profiling activities include:

- Developing and using provider-specific reports that include a multidimensional assessment of performance considering clinical, administrative and member satisfaction indicators that are accurate, measurable and relevant to the enrolled population.
- Establishing benchmarks and goals for performance.
- Providing feedback to individual participating providers regarding the results of their performance and the overall performance of the Humana Healthy Horizons provider network.

To supplement those reports and feedback, we meet with practices on a regular basis to review data related to performance measures and work with providers to identify opportunities for improvement.

Provider participation in the quality assessment and performance improvement program

Network providers are contractually required to comply with Humana Healthy Horizons' QAPI program, which includes providing member records for assessing quality of care and 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 Healthy Horizons to use provider performance data.

Humana Healthy Horizons evaluates the effectiveness of the QAPI program on an annual basis. The annual report reviews completed and continuing QAPI activities, assesses the progress in meeting goals, addresses the quality of clinical care and service, measures trends to assess performance in quality of clinical care and quality of service, identifies any corrective actions implemented or corrective actions which are recommended or in progress, and identifies any modifications to the QAPI program.

Information regarding the QAPI program is available on request. To receive a written copy of Humana Healthy Horizons' quality program and its progress toward goals, you can email OklahomaMedicaidQuality@Humana.com or call Provider Services Contact Center at **855-223-9868 (TTY: 711)**.

Oklahoma PCP quality recognition programs

Humana Healthy Horizons is committed to reducing costs and improving quality of care in the communities we serve. We developed value-based payment programs that allow PCPs to earn financial incentives based on quality and clinical outcomes. The programs are designed based on the provider's panel size and engagement. PCPs managing a panel with a minimum of 30 Humana Healthy Horizons members as of the end of February and December of each calendar year may be eligible to participate in an upside-only, pay-for-performance program with incentive payments to providers for meeting quality measure goals that encourage timely access to care and improved outcomes. PCPs with larger panels also may be eligible to participate in shared savings or two-sided risk arrangements. If you are interested, reach out to your Provider Relations representative for more information. Quality (e.g., pay-for-performance) incentives are reviewed and reimbursed annually one quarter in arrears to allow for reporting/data collection. Shared savings or two-sided arrangements are reconciled on an agreement-specific basis.

Chapter 19: Fraud, waste and abuse policy

You must integrate specific controls into your practice's policies and procedures to help ensure prevention and detection of potential fraud, waste or abuse, or subsequent correction of identified fraud, waste or abuse. You must educate your employees about:

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

Humana Healthy Horizons and OHCA should be notified immediately if you or your office staff:

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

Information can be reported via anonymous phone call to Humana's fraud hotline at **800-614-4126**. All information is kept confidential. Entities are protected from retaliation under 31 U.S.C.3730(h) for False Claims Act complaints. Humana Healthy Horizons maintains a no-retaliation policy for callers, using a zero-tolerance policy to prevent retribution or retaliation for individuals who report suspected misconduct. You also may call Humana Healthy Horizons at **800-4HUMANA** (800-448-6262) and the Oklahoma DHS at **800-784-5887**.

In addition, providers may use the following contacts:
Phone:
Special Investigations Unit (SIU) Hotline: **800-614-4126** (Monday through Friday, 7 a.m. to 3 p.m Central time., 24/7 voicemail access)
Ethics Help Line: **877-5-THE-KEY** (877-584-3539)
Email:
SIUReferrals@humana.com or ethics@humana.com
Online:
Ethicshelpline.com or Humana.com

Chapter 20: Credentialing and recredentialing

Humana Healthy Horizons will transition to a credentials verification organization (CVO) for credentialing and recredentialing activities by July 1, 2025, as prescribed by OHCA. Until the CVO is implemented, Humana considers OHCA's provider enrollment status when making determinations for network participation for the Humana Healthy Horizons provider population. Humana will continue to monitor providers and confirm they remain in good standing with federal and state entities during the interim period. Network enrollment requests from all provider types are completely processed within 45 days of receipt of a completed credentialing application, including all necessary documentation and attachments and a signed provider agreement. Humana may request an additional 15 days to process enrollment applications with approval from OHCA

Providers can mail a completed Council for Affordable Quality Healthcare (CAQH) application or Oklahoma's Uniform Credentialing application to:
Humana
Attention: Credentialing
101 E Main St Louisville, KY 40202
Fax: **502-508-0521**

Practitioner credentialing and recredentialing

Any provider appearing in the provider directory must complete OHCA's enrollment process. Providers subject to OHCA enrollment prior to Humana network participation include, but may not be limited to the following:

- Medical and osteopathic doctors
- Oral surgeons
- Chiropractors
- Podiatrists
- Dentists
- Optometrists
- Advanced practice registered nurse practitioners (APRN)
- Clinical nurse specialists (CNS)
- Certified nurse midwives (CNM)
- Physician assistants (PA)
- Physical and occupational therapists
- Audiologists
- Speech/language therapists/pathologists
- Other licensed or certified practitioners, including physician extenders who act as PCPs or those that appear in the provider directory
- Certain individuals that render services and are not required to be licensed or certified

Behavioral health provider types:

- Psychiatrists and other practitioners
- Licensed clinical addiction counselor (LCAC)
- Doctoral or master's level psychologists who are state licensed
- Licensed behavioral practitioner (LBP)
- Licensed independent practice school psychologist
- Master's level clinical social workers who are state licensed
- Master's level clinical nurse specialists or psychiatric nurse practitioners who are state licensed
- Master's level licensed marriage and family therapists who are state licensed
- Master's level professional counselors (LPC) who are state licensed
- Board-certified behavior analysts (BCBA)
- Other behavioral health specialists who may be within the scope of credentialing and are licensed by the state to practice independently or as required by state regulations
- Certain individuals that render services and are not required to be licensed or certified

Organizational credentialing and recredentialing

Organizational providers subject to OHCA enrollment prior to Humana network participation include, but are not limited, to:

- Ambulatory surgical centers
- Clinical laboratories
- Providers of outpatient diabetes self-management training
- Dialysis centers/end-stage renal disease (ESRD) clinics
- DME/home medical equipment (HME) providers
- FQHCs
- Health departments
- Hearing-aid dealers
- Home health agencies
- Hospice providers
- Hospitals
- IHCPs/tribal facilities
- Mobile X-ray clinics/freestanding X-ray clinics
- Outpatient physical therapy and speech pathology facilities
- Pharmacies
- Rehabilitation facilities/comprehensive outpatient rehabilitation facilities (CORF)
- RHCs
- School-based health clinics
- Skilled nursing facilities (SNF)/extended care facility

Behavioral healthcare facilities providing mental health or substance use services in settings described below are also subject to OHCA enrollment prior to Humana network participation, and include, but are not limited to:

- Inpatient
- Residential/extended care facilities
- Ambulatory

School-based provider assessment

School-based providers subject to OHCA enrollment prior to Humana network participation include, but are not limited to:

- Physical and occupational therapists and assistants
- Speech and language pathologists/therapists and assistants
- Licensed psychologists
- Oklahoma State Department of Education (OSDE)-certified school psychologist (must be an employee of the district)
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapists (LMFT)
- Licensed professional counselor (LPC)
- Licensed behavioral practitioner (LBP)
- Behavioral health providers under supervision must have a master's degree and be under active supervision approved by the licensing board.
- Registered nurse (RN)
- Licensed practical nurse (LPN) under the supervision of an RN
- Paraprofessionals, contracted by OHCA as school-based paraprofessionals

Humana adheres to the credentialing process established by the OSDE when assessing school-based providers.

Provider rights in credentialing

Providers have the right to review, on request, information submitted to support their credentialing application to the Humana Credentialing department. Humana keeps all submitted information confidential and secured. Access to electronic credentialing information is password protected and limited to staff that require access for business purposes.

Providers 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 provider is notified and given the opportunity to correct information prior to presentation to the credentialing committee. Providers have the right to be informed of the status of their credentialing or recredentialing application on written request to the Credentialing department.

Provider responsibilities in credentialing

Network providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. Humana Healthy Horizons initiates immediate action if the participation criteria are no longer met. Network providers are required to inform Humana Healthy Horizons of changes in status, including but not limited to:

- Being named in a medical malpractice suit
- Involuntary changes in hospital privileges
- Involuntary changes in licensure or board certification
- Occurrence of an event reportable to the National Practitioner Data Bank (NPDB)
- Federal, state or local sanctions
- Complaints

Chapter 21: Delegated services, policies and procedures

Scope

The guidelines and responsibilities outlined in this section are applicable to all contracted Humana delegated entities (delegate). The policies in Humana's Provider Manual for physicians, hospitals and other healthcare providers (manual) also apply to delegated entities.

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

Overview

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

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

Delegated providers must comply with the responsibilities outlined in this section of this manual. Additional resources for delegated providers are available on **Humana's website**. For more information on delegation, please contact your assigned Provider Relations representative.

Oversight

Although a health plan can delegate the authority to perform a function, it cannot delegate the responsibility for ensuring the function is performed in an appropriate and compliant manner. Since Humana remains responsible for the performance and compliance of any function that is delegated, Humana must provide oversight of the delegate.

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

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

The delegation process begins with Humana performing a pre-delegation audit prior to any function being delegated to a prospective entity, which includes evaluation of a prospective delegate's compliance and performance capacity. After approval and an executed delegation agreement, Humana performs an annual audit on an ongoing basis until the delegation agreement is terminated. At a minimum, these audits include a review of the following applicable documents:

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

Humana continues to monitor all delegated entities through the collection of periodic reporting outlined within the delegation agreement. Humana provides the templates and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or updated Humana standards. All changes are communicated to the delegate at such time.

Corrective action plans

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

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

UM delegation

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

UM activities and responsibilities

All delegates performing UM activities must comply with and meet the rules and requirements for processing of 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's policies and procedures.

Humana 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.

Delegate is to conduct the following functions regarding initial determination for inpatient and SNF stays:

- Maintain policies and procedures that address all aspects of the UM process including a member's right to a second opinion. Policies and procedures must be formally reviewed, revised, dated and signed annually. Effective dates are present on policies or on a policy master list.
- Perform preadmission review and authorization, including medical necessity determinations based on approved criteria, specific benefits and member eligibility.
- Expedite determinations (as required) and maintain an expedited determinations log. Submit log as required by regulatory and accreditation organization standards.
- Agree not to have a more stringent preauthorization and notification list than Humana's, posted on **Humana.com/PAL**.
- Use Humana's step therapy preauthorization list when implementing a step therapy regimen.
- Notify member, facility and provider of decision on initial determination. For adverse determinations, maintain denial log and submit as required by regulatory and accreditation organization requirements. The delegate is to perform the following concurrent review activities relevant to inpatient and SNF stays:
  - Provide on-site or telephone review for continued stay assessment using approved criteria.
  - Identify potential quality-of-care concerns including, but not limited to, hospital reportable incidents, sentinel events and never events, and notification to the local health plan for review within 24 hours of identification or per contract. Humana does not delegate quality-of-care determinations.
  - Provide continued stay determinations and maintain a denial log for submission to Humana as directed.
  - Notify member, facility and provider of decision on concurrent determination.

The delegate performs discharge planning and retrospective review activities related to inpatient and SNF stays. The delegate also conducts retrospective review functions as related to ambulatory care.

Claims delegation

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

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

Claims performance requirements

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

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

- Delegate must accurately process at least 95% of all delegated claims according to Humana requirements and in accordance with state and federal laws, rules, and regulations and/or any regulatory or accrediting entity to which Humana is subject.
- Delegate must meet applicable state and/or federal requirements to which Humana is subject for denial and appeals language in all communications made to members and use Humana's member letter template.
- Delegate should forward all requests to Humana on receipt, as Humana does not delegate nonparticipating provider reconsideration requests.
- Delegate must provide a financial guarantee, acceptable to Humana, prior to implementation of any delegation of claims processing, such as a letter of credit, to ensure its continued financial solvency and ability to adjudicate and process claims. Delegate must submit appropriate financial information on request as proof of its continued financial solvency.
- Delegate must supply staff and systems required to provide claims and encounter data to Humana as required by state and federal rules, regulations and Humana. Refer to your Process Integration Agreement for details.
- Delegate must use and maintain a claims processing system that meets current legal, professional and regulatory requirements.
- Delegate should print its name and logo on applicable written communications, including letters or other documents, related to adjudication or adjustment of member benefits and medical claims.

Credentialing delegation

All delegates performing credentialing/recredentialing activities must comply with and meet the rules and requirements for credentialing and recredentialing providers as established or implemented by the state. In addition, they must conduct all credentialing and recredentialing activities in accordance with NCQA standards, including maintaining a credentialing committee, a credentialing and recredentialing program and all related policies, procedures, and processes in compliance with these requirements.

Humana is responsible for the collection and evaluation of ongoing monitoring of sanctions and complaints. In addition, Humana retains the right to approve, deny, terminate or suspend new or renewing practitioners and organizational providers from participation in any of a 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, delegate should submit reports of all credentialing approvals and denials within 30 days of the final credentialing decision date to Humana. Delegate should, at a minimum, include the following elements in credentialing reports to Humana:

- 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)

Humana legal regulatory and accreditation requirements

The delegate must comply with the following requirements:

- Submit any material change in the performance of delegated functions to Humana for review and approval prior to the effective date of the proposed changes.
- Obtain and maintain, in good standing, a third-party administrator 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's record retention policy for all delegated function documents, which is 10 years.

Sub-delegation

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

In addition, Humana 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.

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

If Humana approves the sub-delegation, the delegate must provide Humana documentation of a written sub- delegation agreement that:

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

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

Delegate agrees to monitor the subcontractor with monthly federal and state government program exclusion checks for Medicare and Medicaid providers and must maintain such records for monitoring activities. If delegate finds that a provider, subcontractor or employee is excluded from any federal and/or state government program, said provider is immediately removed from providing direct or indirect services for Humana members.

Appeals and grievances

Humana member appeals/grievances and expedited appeals are not delegated to a delegated entity, including any appeal made by a physician/provider on behalf of a member. Humana maintains all member rights and responsibility functions except in certain special circumstances. Therefore, the delegate who receives a grievance/appeal must:

- Forward all standard member appeals/grievances to Humana within one business day by calling **855-223-9868 (TTY: 711)** or faxing the appeal/grievance to **800-949-2961**.
- Forward all expedited appeals immediately on notification/receipt by calling **855-223-9868 (TTY: 711)** or faxing the appeal or grievance to **800-949-2961**. When faxing, delegate must provide the following information: date and time of receipt, member information, summary of the appeal or grievance, all denial information, if applicable, and summary of any actions taken, if applicable.
- Promptly effect the appeal decision as rendered by Humana and handle any requests received from Humana in an expedited manner.
- Handle physician, provider, hospital and other healthcare provider/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 claims payment and denials.

Definitions

Behavioral health emergency – A situation in which a member presents at imminent risk of behaving in a way that could result in serious harm or death to self or others.

Behavioral health services – A wide range of diagnostic, therapeutic and rehabilitative services used in the treatment of mental illness, substance abuse and co-occurring disorders.

Care coordination/care management – A process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the member's needs using advocacy, communication, and resource management to promote quality and cost-effective interventions and outcomes. Based on the needs of the member, the care manager arranges services and supports across the continuum of care, while ensuring that the care provided is person-centered.

Continuity of care period – The ninety (90) day period immediately following a member's enrollment with the Contractor whereby established member and provider relationships, current services, and existing PAs and care plans shall remain in place.

Contract – As a result of receiving an award from OHCA and successfully meeting all readiness review requirements, the agreement between Humana and OHCA where Humana will provide Medicaid services to SoonerSelect Program Members, comprising the contract and any contract addenda, appendices, attachments, or amendments thereto, and paid by OHCA as described in the terms of the agreement.

Contracted entity – An organization or entity that enters into or will enter into a capitated contract with OHCA for the delivery of medical, pharmacy, and behavioral health services not covered in this contract that will assume financial risk, operational accountability, and Statewide or regional functionality as defined in this act in managing comprehensive health outcomes of Medicaid members. For purposes of this Contract, the term Contracted Entity includes an accountable care organization, a PLE, a Commercial Plan, or any other entity as determined by OHCA.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Screening and diagnostic services to determine physical or mental defects in eligibles or members under age 21 and health care, treatment, and other measures to correct or ameliorate any existing defects and/or chronic conditions discovered.

Eligible – An individual who qualifies for SoonerSelect Program coverage.

Emergency medical transportation – An ambulance transport that is required because no other effective and less costly mode of transportation can be used due to the member's medical condition. The transport is required to transfer the member to and/or from a medically necessary service not available at the primary location.

Emergency services – Health care services that are furnished by a provider qualified to furnish such services and needed to evaluate, treat, or stabilize an emergency medical condition in the emergency room, hospital, or other inpatient setting.

Member – A SoonerCare eligible individual who has been enrolled in a SoonerSelect Program CE.

Family planning services and supplies – Services and supplies described in § 1905(a)(4)(C) of The Act, including contraceptives and pharmaceuticals for which OHCA claims or could claim federal match at the enhanced rate under § 1905(a)(5) of The Act.

Health care services – All Medicaid services provided by Humana or a contracted entity in any setting, including but not limited to medical care, behavioral health care, and pharmacy.

Health risk screening – A screening tool developed by Humana or a contracted entity, and approved by OHCA, to obtain basic health and demographic information, identify any immediate needs a member may have and assist in assigning a risk level for the member to determine the level of care management needed.

Healthcare Effectiveness Data and Information Set (HEDIS®) – A tool supplied by the NCQA and used by health plans to measure performance on important dimensions of care and service. This information set contains several measures designed to evaluate quality of care in a standardized fashion that allows for comparison between health plans.

Home Health Care – Wide range of Health Care Services that can be given in your home for an illness or injury. These services are furnished by a professional caregiver in the individual home where the patient or client is living as opposed to group settings such as clinics or nursing homes.

Hospice Services – Is a comprehensive, holistic program of care and support for terminally ill patients and their families. Hospice care changes the focus to comfort care (palliative care) for pain relief and symptom management instead of care to cure the patient's illness.

Hospital outpatient care – Any health care consultation, procedure, treatment, or other service that is administered without an overnight stay in a hospital or medical facility.

Hospitalization – Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Indian Health Care Provider – A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Medically necessary or medical necessity – A standard for evaluating the appropriateness of services. Medical Necessity, as established under OAC 317:30-3-1, is established through consideration of the following standards:

a. Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis, or treatment of symptoms of illness, disease, or disability. b. Documentation submitted to request services or substantiate previously provided services must demonstrate through adequate objective medical records, evidence sufficient to justify the member's need for the service.
c. Treatment of the member's condition, disease, or injury must be based on reasonable and predictable health outcomes.
d. Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the member, family, or medical provider.
e. Services must be delivered in the most cost-effective manner and most appropriate setting; and
f. Services must be appropriate for the member's age and health status and developed for the member to achieve, maintain, or promote functional capacity or age-appropriate growth and development.

Also aligning with federal standards, "Medically Necessary services" are no more restrictive than the State Medicaid program including Quantitative and Non-Quantitative Treatment Limits (NQTL), as indicated in state statutes and regulations, the state plan, and other state policies and procedures.

Also aligning with federal standards, "Medically Necessary services" are no more restrictive than the State Medicaid program including Quantitative and Non-Quantitative Treatment Limits (NQTL), as indicated in State statutes and regulations, the State Plan, and other State policies and procedures. The Contractor shall cover Medically Necessary services related to a member's ability to attain, maintain, or regain functional capacity.

Network – A group of participating providers linked through provider agreements or contracts with the contractor to supply a range of services. Also referred to as a provider network.

Non-participating provider – A physician or other Provider who has not contracted with or is not employed by the Contractor to deliver services under the SoonerSelect Program.

Non-Urgent Sick Visit – Medical care given for an acute onset of symptoms which is not emergent or urgent in nature. Examples of Non-Urgent Sick Visits include cold symptoms, sore throat, and nasal congestion. Requires face-to-face medical attention within seventy-two (72) Hours of Member notification of a non-urgent condition, as clinically indicated.

Oklahoma Health Care Authority – The single state agency for Medicaid in Oklahoma and the Agency with direct oversight of the SoonerSelect Program.

Oklahoma State Department of Health – The OSDH, through its system of local health services delivery, is ultimately responsible for protecting and improving the public's health status through strategies that focus on preventing disease. Three major service branches, Community & Family Health Services, Prevention & Preparedness Services and Protective Health Services, provide technical support and guidance to sixty-eight (68) county health departments as well as guidance and consultation to the two (2) independent city-county health departments in Oklahoma City and Tulsa.

Open Enrollment Period – The annual period, as defined by OHCA, when Members and Eligibles can enroll in a Contract for the SoonerSelect Program.

Overpayment – Any payment made to a Participating Provider by the Contractor to which the Participating Provider is not entitled or any payment to the Contractor by OHCA to which the Contractor is not entitled under Title XIX of The Act and under the SoonerSelect Program.

Participating provider – A physician or other provider who has a contract with or is employed by Humana to provide services to members under the SoonerSelect Program, or in network.

Pediatric – Children from birth through age 21.

Performance Improvement Projects – A concentrated effort on a problem, consistent with 42 C.F.R. § 438.330, and designed to achieve significant improvement, sustained over time, in health outcomes and Member satisfaction and must include the following elements:
a. Measurement of performance using objective quality indicators.
b. Implementation of interventions to achieve improvement in the access to and quality of care.
c. Evaluation of the effectiveness of the interventions; and
d. Planning and initiation of activities for increasing or sustaining improvement.

Personal Care Services – Assistance to an individual in carrying out ADLs, such as bathing, grooming and toileting, or in carrying out instrumental Activities of Daily Living, such as preparing meals and doing laundry or errands directly related to the Member's personal care needs, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. The Personal Care Service requires a skilled nursing assessment of need, development of a Care Plan to meet identified personal care needs, Care Plan oversight and periodic re-assessment and updating, if necessary, of the Care Plan. Personal Care Services do not include technical services such as, tracheal suctioning, bladder catheterization, colostomy irrigation and operation of equipment of a technical nature.

Physician Services – Services provided by an individual licensed under state law to practice medicine or osteopathy.

Plan – Managed care entity that manages the delivery of health care services.

Prescription Drug Coverage – Health Insurance or entity that helps pay for prescription drugs and medications.

Presumptive Eligibility – A period of temporary SoonerCare eligibility provided to individuals determined by a qualified entity, on the basis of Applicant self-attested income information, to meet the eligibility requirements for a Modified Adjusted Gross Income (MAGI) eligibility group.

Pregnancy-related services – In accordance with 42 C.F.R. § 440.210, services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having become pregnant.

Primary care provider – A provider under contract with Humana to provide primary care services and case management, including securing all medically necessary referrals for specialty services and PAs.

Prior authorization – A requirement that a member obtain Humana's approval before a requested medical service is provided or before services by a non-participating provider are received. PA is not a guarantee of claims payment; however, failure to obtain PA may result in denial of the claim or reduction in payment of the claim.

Protected Health Information – Information considered to be individually identifiable health information, as described in 45 C.F.R. § 160.103.

Provider – Includes both participating and non-participating providers.

Provider Agreement – An agreement between the Contractor and a Participating Provider that describes the conditions under which the Participating Provider agrees to furnish covered services to Members.

Provider Complaint – A verbal or written expression by a Provider involving dissatisfaction with the Contractor's policies, procedures, communication, or other action by the Contractor.

Provider-Preventable Conditions – A condition occurring in any inpatient hospital setting, identified by the Secretary under Section 1886(d)(4)(D)(iv) of The Act for purposes of the Medicare program identified in the State Plan as described in Section 1886(d)(4)(D)(ii) and (iv) of The Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in Pediatric and obstetric patients. Also includes a condition occurring in any health care setting that is identified in the State Plan, has been found by OHCA, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; has a negative consequence for the Member or Eligible; is auditable; and includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; and any surgical or other invasive procedure performed on the wrong patient.

Quality Assessment and Performance Improvement – A process designed to address and continuously improve Contractor quality metrics. The QAPI activities will provide the Contractor with data which it shall use, in conjunction with input from Members and other stakeholders, to improve the delivery of care and care outcomes. The program shall evaluate all SoonerSelect Program population groups, care settings, and types of services, including physical health services, Behavioral Health Services, and pharmacy benefits. The Contractor's QAPI program shall comply with every aspect of State and federal law, including 42 C.F.R. § 438.330 in its entirety.

Quality Improvement Committee – A committee within the Contractor's organizational structure that oversees all QAPI functions. The Contractor's Chief Medical Officer shall chair the committee.

Rural Health Clinic – Clinics meeting the conditions to qualify for RHC reimbursement as stipulated in Section 330 of the Public Health Services Act. RHCs certified for participation in the Medicare Program are considered eligible for participation in the Medicaid Program. RHCs may be Provider-based (i.e., clinics that are an integral part of a hospital, skilled nursing facility, or home health agency that participates in Medicare) or independent (freestanding) and may include Indian Health Clinics. To participate, a RHC must have a current contract on file with OHCA.

Skilled Nursing Care – Services from licensed nurses, technicians, and/or therapists in a Member's home.

Social Determinants of Health – Conditions in the places where a member lives, learns, works, and plays that affect the Member's health and quality-of-life risks and outcomes.

SoonerCare – The Oklahoma Medicaid program.

SoonerSelect – Oklahoma's Medicaid service delivery model that provides comprehensive medical, pharmacy, dental, and behavioral health benefits through contracted entities.

Specialist – A Provider, whose practice is limited to a particular branch of medicine, including one who, by virtue of advanced training is certified by a specialty board as being qualified to so limit their practice.

Standing Referral – A referral from a PCP or the Contractor for a Member needing access to multiple appointments with the Specialist over a set period of time, such as a year, without seeking multiple referrals.

State – When not otherwise specified, refers to a government entity or entities within the State of Oklahoma.

Telehealth – Means the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to exclude store and forward technologies, between a patient and a health care Provider with access to and reviewing the patient's relevant clinical information prior to the Telehealth visit. In accordance with Oklahoma law, including OAC 317:30-3-27 and 59 O.S. § 478, Telehealth shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission.

Third-Party Liability – All or part of the expenditures for a Member's medical assistance furnished under the OHCA State Plan that may be the liability of a third-party individual, entity, or program.

Transition of care – The movement of a patient from one (1) setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Urgent Care – Medical care provided for a condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse), such that a reasonably prudent layperson could expect that the absence of medical attention within twenty-four (24) hours could result in:

a. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
b. Serious impairment to bodily function; or
c. A serious dysfunction of any body organ or part.

Value-added benefit – Any product, benefit, or service offered by the contractor that is not a covered benefit. These benefits are subject to change annually as determined by the contractor and OHCA.

Waste – The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program; generally, not considered to be caused by criminally negligent actions but rather the misuse of resources.

Acronyms

AAP	American Academy of Pediatrics
ABP	Alternative Benefit Plan
ACIP	Advisory Committee of Immunization Practices
ADL	activities of daily living
AHA	American Hospital Association
AHRQ	Agency for Health Care Research and Quality
AI/AN	American Indian/Alaska Native
AMA	American Medical Association
ANSI	American National Standards Institute
APA	American Psychiatric Association
APRN	advance practice registered nurse
ASAM	American Society of Addiction Medicine
ASC	Accredited Standards Committee
B-MOD	behavior modification
CFR	Code of Federal Regulations
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	corrective action plan
CAQH	Council for Affordable Quality Healthcare
CCBHC	certified community behavioral health clinics
CDS	controlled dangerous substance
CIS	community integration services
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
COB	coordination of benefits
CPT	Current Procedural Terminology
CVO	credential verification organization
DAODAS	Department of Alcohol and Other Drug Abuse Services
DEA	Drug Enforcement Administration
DME	durable medical equipment
DMH	Department of Mental Health
DVT	deep vein thrombosis
EAF	electronic attestation form
EDI	electronic data interchange
EFT	electronic funds transfer
EHR	electronic health record
EMR	electronic medical record
EOB	explanation of benefits
EOP	explanation of payment
EOR	explanation of remittance
EPSDT	Early and Periodic Screening, Diagnostic and Treatment

EQR	external quality review
EQRO	external quality review organization
ERA	electronic remittance advice
eRx	E-prescribing
EVV	electronic visit verification
FDA	The Food and Drug Administration
FFS	fee-for-service
FQHC	federally qualified health centers
FS	family support
FWA	Fraud, waste and abuse
HCPCS	Healthcare Common Procedure Coding System
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	The United States Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
ICD-10-CM	International Classification of Diseases, Tenth Edition, Clinical Modification
ID	identification
IHCP	Indian Health Care Provider
IHCP	Indian Health Coverage Program
IHS	Indian Health Service
IMD	Institutions for Mental Disease
JJ	juvenile justice
LEP	limited English proficiency
LBP	licensed behavioral practitioner
LCSW	licensed clinical social worker
LMFT	licensed marriage and family therapists
LPC	licensed professional counselor
LTSS	long-term services and supports
MBHO	managed behavioral healthcare organization
MCO	managed care organization
MCG	Milliman Care Guidelines
MDT	multi-disciplinary care team
MHPAEA	Mental Health Parity and Addiction Equity Act
MPL	OHCA Master Provider List
MRDRs	medical record documentation reviews
MTM	medication therapy management
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NEMT	nonemergency medical transportation
NICU	neonatal intensive care unit
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier

NUBC	National Uniform Billing Committee
OHCA	Oklahoma Health Care Authority
OKDHS	Oklahoma Department of Human Services
OLIP	Oklahoma Lock-in Program
OT	occupational therapy
OTC	over the counter
PA	Physician Assistant
PA	prior authorization
PACT	Program of Assertive Community Treatment
PAF	practitioner assessment form
PBM	pharmacy benefit manager
PCP	primary care provider
PCS	personal care services
PDL	preferred drug list
PDN	private duty nursing
PHI	protected health information
PHP	partial hospitalization program
PII	personally identifiable information
PSS	peer support services
PT	physical therapy
QAPI	quality assessment and performance improvement program
RHC	rural health clinics
SDOH	social determinants of health
SIU	special investigations unit
SMI	serious mental illness
SNF	skilled nursing facility
ST	speech therapy
SUD	substance use disorder
TCC	therapeutic childcare
TIN	Tax ID number
TTY	teletype
UM	utilization management
US/U.S.	United States
VAB	value-added benefit