2026

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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Contents

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 Healthy Horizons as easy as possible, facilitating high-quality care and a positive experience for 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 serves as your primary point of contact to facilitate communication. If you do not know who your dedicated provider relations representative is, please email **OKMedicaidProviderRelations@humana.com**, and we can connect you directly to your assigned representative.

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 while reducing 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 Healthy Horizons policies and procedures.

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

- Formalizes Humana Healthy Horizons' commitment to honest communication within the company and within the community, inclusive of our providers, members and employees

- Develops and maintains a culture that promotes integrity and ethical behavior
- Facilitates compliance with all applicable local, state and federal laws and regulations
- Implements a system for early detection and noncompliance reporting with laws and regulations; fraud, waste and abuse concerns; or noncompliance with Humana Healthy Horizons policy, and professional, ethical or legal standards
- Allows Humana Healthy Horizons to resolve problems promptly and minimizes negative impact to our members or business, including financial losses, civil damages, penalties and sanctions

The following outlines general compliance and ethical 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 – Friday, 8 a.m. – 5 p.m., Central time.

Accreditation

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

Accessing benefits provided by the state of Oklahoma

You can obtain information about benefits provided by the state by visiting **OHCA's website**.

Provider portal

Humana partners with Availity Essentials™ to allow providers to reference member and claim data for multiple payers using one login. Availity Essentials helps providers:

- Check eligibility and benefits
- Access certificate of coverage
- Submit preauthorization and referral requests
- Check status of preauthorization and referral requests
- Access plans of care
- Access members' summaries

- Respond to medical record requests
- Check claim status
- Check claim submission
- Submit disputes and appeals
- Check remittance advice
- Manage overpayments
- Request electronic remittance advice/electronic funds transfer (ERA/EFT) enrollment
- Access provider directory
- Access Humana-specific applications, resources and news

To learn more, call Availity Essentials at **800-282-4548** or visit **Availity Essentials' website**.

Communicating with Humana Healthy Horizons

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**, Monday – Friday, 7 a.m. – 7 p.m., Central time, **Humana.com/OKPA**
PA for pharmacy	**800-555-2546**
Pharmacy help desk	**844-918-0785**
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: Humana Special Investigations Unit 1100 Employers Blvd. Green Bay, WI 54344
Tribal concierge unit	**855-223-9868**
Provider complaints	**OKMedicaidProviderRelations@Humana.com**

Contact name	Contact information
Member grievances and appeals	Humana Member grievances and appeals P.O. Box 14163 Lexington, KY 40512-4163
Claims	Humana Claims P.O. Box 14359 Lexington, KY 40512-4359
NICU admissions	**855-391-8655**, Monday – Friday, 7 a.m. – 5 p.m., Central time
Overpayments	Humana Healthcare Plans P.O. Box 931655 Atlanta, GA 31193-1655

Helpful website resources

Providers may obtain plan information from **Humana Healthy Horizons' provider information** and **Humana's provider publications website**. This includes details on the following:

- Health and wellness programs
- Provider publications, including the provider manual, Humana Physician News (quarterly newsletter) and program updates
- Pharmacy services
- Claim resources
- Quality resources
- What's new

For help or more information regarding web-based tools, please call Provider Services at **855-223-9868**.

Communicating with OHCA

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 Healthy Horizons. 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 Humana Healthy Horizons. Newborns who are assigned to Humana Healthy Horizons whose mother is not a Humana Healthy Horizons member, from the first day of the month through the 15th day of the month, are enrolled effective the first day of the following month. Newborns who are assigned to Humana Healthy Horizons whose mother is not a Humana Healthy Horizons member, on the 16th day of the month through the last day of the month, are enrolled effective the first day of the second following month. The delivery hospital is required to enter the birth record into Oklahoma's Certificate of Live Birth, Hearing, Immunization and Lab Data birth record system. 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**.

Automatic renewal

If Humana Healthy Horizons members lose Medicaid eligibility but become eligible again within 60 days, they are automatically re-enrolled 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 care provider (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 Healthy Horizons members choose or are assigned to an in-network 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 also are required to know how to screen and refer members for behavioral health conditions. Members can select a PCP from our provider directory.

A PCP is assigned to a member if one is listed on the supplemental enrollment file and the listed PCP is in the Humana Healthy Horizons network. If a PCP is not on the file or the listed PCP is not in the Humana Healthy Horizons network, members have 30 days to choose a PCP. If a member does not choose a PCP on enrollment, a PCP is automatically assigned to the member. The Humana Healthy Horizons internal system can identify a member's previous PCP (if applicable) within the Humana Healthy Horizons 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 Healthy Horizons PCP panel. The Humana Healthy Horizons internal editing system also ensures that the auto-assigned PCP is age-appropriate for the member (e.g., pediatric members are assigned to pediatricians 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.

Members can change PCPs during the first 30 days of a member's enrollment and Humana Healthy Horizons backdates the effective date to the first of the month of the requested change. Members initiate the change by calling the Member Services contact center or by logging in to their MyHumana secure portal.

Referrals for release due to ethical reasons

Humana Healthy Horizons 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 situations when performing a procedure or delivering care is contrary to your conscience, religious beliefs or ethical principles, 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 Healthy Horizons to provide Medicaid services to beneficiaries. In instances when 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 the 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 Healthy Horizons at the following address:

Humana Healthy Horizons Provider Relations

210 Park Ave, Suite 2800
Oklahoma City, OK 73102
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

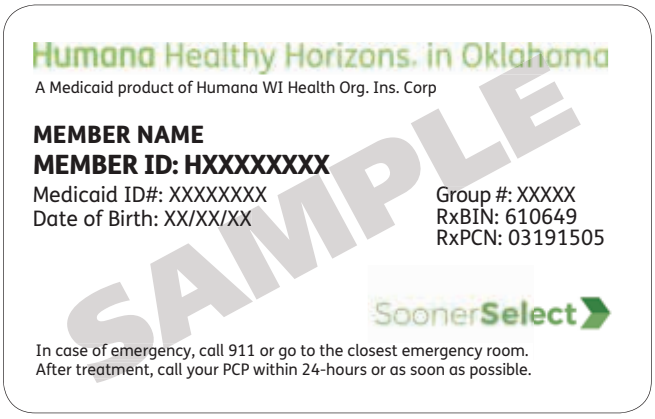
All new Humana Healthy Horizons members receive a Humana Healthy Horizons member ID card. After the issuance of the initial card, a new card is issued only when the card information changes, when a member loses a card or when a member requests an additional card. The member ID card is used to identify 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.

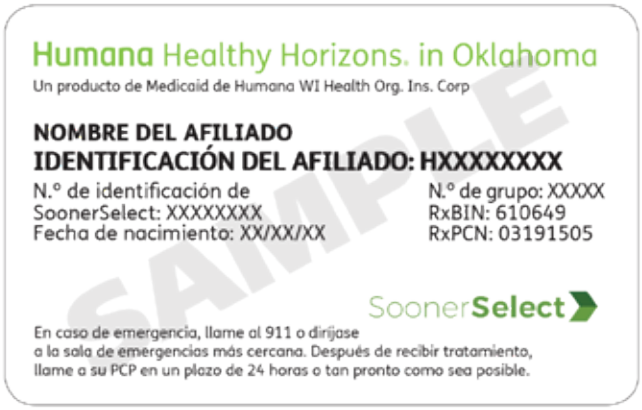
Information included on the ID card includes:

- 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 Healthy Horizons.
- 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.



Tarjeta en español de SoonerSelect de Oklahoma



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**.

Member disenrollment

Members can be disenrolled from Humana Healthy Horizons 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 contact center 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 (CEs) 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 Oklahoma Contract 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 allow a member to disenroll without cause.

Chapter 3: Member support services and benefits

Member services

The Humana Healthy Horizons Member Services contact center can assist members who have questions or concerns about services, such as care management, disease management, non-emergency 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 Healthy Horizons is closed the Friday before. If the holiday falls on a Sunday, Humana is closed the Monday after.

Members can access information including 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**.

Non-emergency 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 non-emergency ambulance use.

Humana Healthy Horizons also offers members 21 and older 30 one-way, or 15 round trips, up to 45 miles, per calendar year for nonmedical purposes.

How to obtain non-emergency transportation

If a member requires access to a vehicle, wheelchair van, stretcher services, or nonmedical transportation, providers may contact Modivcare at **877-718-4213**. To cancel a scheduled ride, it is requested that you do so at least 24 hours in advance. Members must provide a minimum of 72 hours (3 days) notice to arrange for routine non-emergency transportation.

Interpreter services

If you need assistance in providing a Humana Healthy Horizons-covered patient with interpretation 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 (TTY: 711)**.

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**. Nurses educate members about the benefits of preventive care and refer them to our disease management and case management programs as appropriate. 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 contracts with Solari to provide a behavioral health services 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 (COC) 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**.

In addition to our Behavioral Health Services Hotline, Oklahoma offers a 988 Mental Health Lifeline, which is a 3-digit calling code that Oklahomans can use to reach a crisis agent. Members can call or text 988 or go to **988 Mental Health Lifeline's website** to chat and receive immediate help 24/7. All 988 callers route to Solari, the 988 vendor in Oklahoma. Solari determines which of those callers are Humana Healthy Horizons members. If the member's call results in receiving a SoonerSelect billable crisis service, then Humana Healthy Horizons receives notification of usage and reaches out to the member within 72 hours to determine the need for further service or referrals.

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 family planning 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 a member experiencing difficulty with their contraceptive method or with concerns with their reproductive health

Chapter 4: Care management and care coordination

The 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 for community benefits and supports

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 by calling **855-223-9868**, Monday – Friday, 8 a.m. – 5 p.m., Central time, 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 that 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 conditions indicating emerging needs or vulnerabilities best suited by assistance from a nonlicensed care coordinator for short-term support to help them address their needs and move to the wellness and prevention level. We also target members to support wellness and emergent needs to help them maintain an optimal level of health, which may include healthy children and adults (e.g., vaccinations, well visits, healthy lifestyle).

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 a member's 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. 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.

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 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.

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 that include, but are 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. 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

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 (VAD), total artificial health (TAH), or immune effector cell therapy (IEC), including chimeric antigen receptor T-cell therapy (CAR T). The Humana Healthy Horizons 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 (including travel and lodging, if eligible)
- 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

For further assistance with transplant services, please call **866-421-5663**, Monday – Friday, 8 a.m. – 5 p.m., Central time, email **transplant@humana.com** or fax **502-508-9300**. Messages left after hours receive a response the next business day.

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. To contact our Care Management team, or if you have a Humana Healthy Horizons-covered patient with chronic conditions who would benefit from this program, please call the Provider Services contact center at **855-223-9868** or email **OKMCDCaseManagement@humana.com**.

Chapter 5: Behavioral health—mental health and substance use services

Humana Healthy Horizons manages behavioral health services through its provider networks, consisting of appropriately credentialed, licensed and/or certified practitioners, facilities, providers and programs. The Humana Healthy Horizons' provider network is comprised of a robust number of crisis service providers, including certified community behavioral health centers, mobile crisis response units, urgent recovery centers, crisis stabilization, free-standing psychiatric facilities and community mental health centers.

Understanding both behavioral and physical health equally affect a person's wellness, Humana Healthy Horizons uses a holistic treatment approach to address a member's mental health and substance use disorders. 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 mental 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 (MAT), including buprenorphine and naltrexone, available in multiple settings including residential
- Opioid treatment programs (OTPs)
- Crisis management

- Applied behavioral analysis therapy (younger than 21)
- Community support services

Inpatient services

Humana Healthy Horizons covers mental health, inpatient substance use disorder, detox and psychiatric residential treatment services. To determine what services require authorization, please review the **prior authorization list (PAL) online**. Inpatient services include, but are not limited to:

- Inpatient psychiatric services in a designated acute 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 demonstration waiver 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 benefits and seek guidance in obtaining such services. The Humana Healthy Horizons network focuses on improving member health through evidence-based practices with the goal 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 that may be provided through primary care include, but are 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 mental health and substance use problems and supports member education related to the specific diagnosis/risk factor(s). Humana Healthy Horizons expects providers to:

- Educate members on 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 to identify and treat 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 nonduplicative 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 mental 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 mental health and SUD
- Provide initial and summary reports to the PCP (after receiving previously mentioned information release)
- Refer members with known, 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 health care 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 inpatient admissions, crisis stabilization, urgent recovery centers and ER visits should incorporate continuity with existing behavioral health therapeutic relationships and ensure engagement with appropriate community behavioral health resources. Discharge planning facilitates a smooth transition post-discharge to the appropriate level of care for the member.

Additionally, Humana Healthy Horizons requires an outpatient follow-up appointment with a behavioral health provider to be scheduled prior to a member's discharge from an inpatient behavioral health treatment facility or ER visit. The appointment must occur within 7 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 with questions about Humana Healthy Horizons or Medicaid; questions about how managed care operates; questions regarding members' benefits, including transportation or behavioral health services; help with accessing our extensive training and education materials; or for any other help they may need.

Like all Humana Healthy Horizons members, American Indian/Alaskan Native (AI/AN) members receive access to the comprehensive physical, behavioral and SDOH services described in this manual. This includes transportation and value-added benefits which Humana Healthy Horizons provides to members in addition to covered benefits described in **Chapter 7 of this manual**. If tribal providers have questions about these benefits and services, including how to assist members accessing these benefits and services, they may call the Provider Services contact center at **855-223-9868**, or if additional assistance is required, email our **tribal government liaison**.

Referrals from IHCPs

In alignment with federal Indian Managed Care protections, 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 purchased and referred care.

Payment for IHCPs

The IHCP is paid for covered Medicaid managed care services in accordance with the requirements set out in section 1932(h) of the Social Security Act and 42 CFR 438.14 and 457.1209. These fees are paid by the Oklahoma Health Care Authority; Humana Healthy Horizons is not responsible for payments to the IHCP. Humana Healthy Horizons maintains a reference copy of this guidance. Please contact your provider relations representative or **our tribal government liaison** for assistance.

For questions about these reimbursement requirements, please contact your provider relations representative or our Provider Services contact center at **855-223-9868**.

American Indian/Alaskan Native member protections

AI/AN members are exempt from cost sharing when receiving services through an Indian Health Service, Tribal Health Program or Urban Indian Organization provider or pharmacy. Humana Healthy Horizons does not impose an enrollment fee, premium or similar charge, and no deduction, copayment, cost sharing or similar charge is imposed against an AI/AN member who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization, or through referral under contract health services. Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization or a health care IHCP through referral under contract health services for the furnishing of an item or service to an AI/AN member who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium or similar charge, and no deduction, copayment, cost sharing or similar charge.

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 OHCA's policies and rules and federal regulations. Please refer to the **Humana Healthy Horizons Preauthorization and Notification Lists for Healthcare Providers** for current prior authorization lists. The services listed below may require prior authorization.

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)	Nonexpansion adults (21 and older)	Expansion adults (21 and older)
Advanced practice registered nurse (APRN)	Covered	Covered	Covered
Allergy testing	Covered	Covered: • Limited to 60 tests every 3 years	Covered: • Limited to 60 tests every 3 years Limit can be exceeded based on medical necessity

Service	Children (younger than 21)	Nonexpansion adults (21 and older)	Expansion adults (21 and older)
Alternative treatment for pain management	Covered	Physical therapy when provided in a non-hospital-based setting: a. Initial evaluation covered without prior authorization (PA) b. 12 hours per year requires PA Chiropractic services: a. Initial evaluation covered without PA b. 12 visits per year requires PA	
Ambulance or emergency transportation	Covered		
Ambulatory surgical center	Covered		
Bariatric surgery	Covered, after meeting pre-surgical evaluation and weight-loss requirements Requires PA	Covered, after meeting pre-surgical evaluation and weight-loss requirements Not covered for treatment of obesity alone; requires PA	
Certified registered nurse anesthetist and anesthesiologist assistants	Covered		
Chemotherapy	Covered		
Clinic services	Covered Some services may require a PA		
Diabetes education	Covered, 10 hours per first year; 2 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; 2 hours per subsequent year	Covered, 10 hours per first year; 2 hours per subsequent year Limits can be exceeded based on medical necessity.
Diagnostic testing entities	Covered Some services may require PA		

Service	Children (younger than 21)	Nonexpansion adults (21 and older)	Expansion adults (21 and older)
Donor human breast milk	Covered during the first year of life; requires PA	Not covered	
Durable medical equipment supplies and appliances	Covered Requires a prescription from a medical provider Some services may require a PA		
EPSDT and early intervention services, including health and immunization history; physical exams, various health assessments and counseling; lab and screening tests; necessary follow-up care; and applied behavioral analysis (ABA) services	Covered Some services may require PA	Not covered	
Emergency room/department	Covered		
Eye care to treat a medical or surgical condition	Covered		
Family planning services	Covered		
Federally Qualified Health Center and rural health clinic services	Covered		
Genetic counseling and testing	Covered for pregnant members and members meeting medical necessity criteria May require PA		

Service	Children (younger than 21)	Nonexpansion adults (21 and older)	Expansion adults (21 and older)
Hearing services	Covered May require PA	Covered as a value-added benefit, members 21 and older can receive the following: • 1 assessment for hearing aids every 3 years • 1 hearing aid per ear and dispensing fee every 3 years • 2 hearing aid fitting/checking visits every 3 years • 48 batteries per hearing aid per year	
Home health care services	Covered		
Hospice (non-hospital based)	Covered for members who have a life expectancy of 6 months or less	Covered for members who have a life expectancy of 6 months or less	Covered for members who have a life expectancy of 6 months or less
Immunizations	Covered		
Infusion therapy	Covered	Covered when medically necessary and not considered a compensable part of the procedure	
Inpatient hospital services	Covered	Covered: a. Inpatient hospital services (inpatient stay): no limit b. Inpatient physician services: covered c. Inpatient surgical services: no limit d. Inpatient rehabilitation hospital services: 90 days per individual per state fiscal year (SFY)	Covered: a. Inpatient hospital services (inpatient stay): no limit b. Inpatient physician services: covered c. Inpatient surgical services: no limit d. Inpatient rehabilitation hospital services: 90 days per individual per SFY Amount limits can be exceeded based on medical necessity.

Service	Children (younger than 21)	Nonexpansion adults (21 and older)	Expansion adults (21 and older)
Laboratory, X-ray, diagnostic imaging and imaging (computerized tomography [CT]/ positron emission tomography [PET] scans and magnetic resonance imaging [MRI])	Covered Some services may require a PA		
Lactation consultant (help with breastfeeding)	Covered for pregnant and postpartum members		
Lodging and meals for the health plan member and/or 1 approved medical escort	Covered Services require PA		
Long-term care hospital services for children	Covered	Not covered	
Mammograms	Covered		
Maternal and infant licensed clinical social worker services	Covered for pregnant and postpartum members		
Non-emergency medical transportation (NEMT) – Hospital/NICU visit	Covered as a value-added benefit All members can receive 1 in-state round trip (2 in-state, 1-way trips) per day for a parent and/or guardian to visit their child during a NICU or inpatient hospital stay.		

Service	Children (younger than 21)	Nonexpansion adults (21 and older)	Expansion adults (21 and older)
Non-emergency medical transportation (NEMT)–Additional passengers	Covered as a value-added benefit: Members using non-emergency medical transportation may be allowed to bring up to 3 children when childcare is not available: • Total number of passengers, including the driver, cannot exceed more than 5 • 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 his/her own car seat provided by the member if required by OK state law.		
Nurse midwives	Covered under EPSDT	Covered	
Nursing facility and intermediate care facilities for individuals with intellectual disabilities (ICF-IID)	Covered for up to 60 days pending a level-of-care determination		
Nutrition services (dietician)	Covered	Covered up to 6 hours per year Nutritional services for treatment of obesity are not covered. Services must be for diagnosing, treating, preventing or minimizing effects of illness.	Covered up to 6 hours per year Nutritional services for treatment of obesity are not covered. Services must be for diagnosing, treating, preventing or minimizing effects of illness. Limits can be exceeded based on medical necessity.
Orthotics	Covered	Not covered	Covered without limitations when medically necessary
Outpatient hospital and surgery services	Covered		

Service	Children (younger than 21)	Nonexpansion adults (21 and older)	Expansion adults (21 and older)
Paid Family Caregiver (PFC)	Covered for children aged 0-20 Limit 40 hours per week	Not covered	Not covered
Physician and physician assistant services	Covered	Covered	Covered
Podiatry	Covered		
Parenteral/enteral nutrition (IV and tube feeding)	Covered Some services may require a PA		
Personal care services	Covered		
Post-stabilization care services	Covered		
Pregnancy and maternity services, including prenatal, delivery and postpartum	Covered		
Prescription drugs	Covered	Covered as a value-added benefit, for members age 21 and older, the six-prescription monthly limit does not apply. Members can receive more prescriptions when needed and there is no limit on the total number of prescriptions you may have. However, members may receive up to 2 brand-name prescriptions each month. A third brand-name prescription may be approved if your doctor says it is medically needed. For more information, please call Member Services or talk with your pharmacy. All prescriptions are subject to state and federal requirements for drug utilization review, safety edits, quantity limits and PA.	
Preventive care and screenings	Refer to EPSDT coverage	Covered 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 no stand-alone preventive services benefit package for adults providing coverage for all services.	

Service	Children (younger than 21)	Nonexpansion adults (21 and older)	Expansion adults (21 and older)
Private duty nurse (PDN)	Covered up to 16 hours per day Additional hours are available for 30 days following a stay in a hospital or when a regular caregiver is not available	Not covered	This service is substituted with skilled nursing under the home health services benefit.
Prosthetic devices	Covered when previously authorized	Only breast prosthesis, support accessories and prosthetic devices are covered when part of surgery Limited coverage with required PA	Covered without limitations when medically necessary
Public health clinic services	Covered	Covered	Covered
Radiation	Covered		
Reconstructive surgery	Covered May require PA	Covered May require PA Noncosmetic 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		
Routine patient cost in qualifying clinical trials	Covered to the extent that the provision of the service would otherwise be covered outside of the participation in the clinical trial		
School-based health related services	Covered	Not covered	
Telehealth	Covered		

Service	Children (younger than 21)	Nonexpansion adults (21 and older)	Expansion adults (21 and older)
Therapy services: physical therapy (PT), occupational therapy (OT) and speech therapy (ST)	OT and PT: a. Initial evaluation covered without PA b. Treatment requires PA ST: a. Evaluation and treatment require PA	Rehabilitative services: a. 15 visits per year for each OT, PT and ST (cumulative total 45 visits)	Habilitative services: a. 15 visits per year for each OT, PT and ST (cumulative total: 45 visits) Rehabilitative Services: a. 15 visits per year for each OT, PT and ST (cumulative total: 45 visits)
Tobacco cessation services	Nicotine replacement therapy products (including patches, gum, lozenges, inhalers and nasal spray) and Zyban®/bupropion to include 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. 8 tobacco cessation counseling sessions per year are covered.		
Organ transplant services	Covered with PA. Kidney and cornea transplants do not need a PA.		
Urgent care centers or facilities	Covered	Covered	Covered
Vision services	Covered under EPSDT with a limit of 2 eyeglass frames per year	Coverage to treat a medical or surgical condition only. As a value-added benefit, members 21 and older receive an annual eye exam. In addition, members can choose one of the following every 2 years: • Eyeglasses include non-high index polycarbonate lenses and a $100 allowance for the frame, or • $100 allowance for the cost of contact lenses, members are responsible for any cost over the allowance	

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.

Service	Children (younger than 21)	Nonexpansion adults (21 and older)	Expansion adults (21 and older)
Prescription drugs	Covered	Covered As a value-added benefit, the monthly prescription limit is waived for members 21 and older. Members can receive more prescriptions when needed and there is no limit on the total number of prescriptions you may have. However, members may receive up to 2 brand-name prescriptions each month. A third brand-name prescription may be approved if your doctor says it is medically needed. All prescriptions are subject to state and federal requirements for Drug Utilization Review, safety edits, quantity limits and PA.	
Medication-assisted treatment (MAT) services	Covered Includes: • Generic buprenorphine/naloxone sublingual tablets • Vivitrol • Methadone		
Tobacco cessation products (to help members quit using tobacco)	Nicotine replacement therapy products (including patches, gum, lozenges, inhalers and nasal spray) and Zyban®/Bupropion to include 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 co-payment.		
Diabetic supplies (insulin, syringes, test strips, lancets and pen needles)	Covered		
Family planning supplies	Covered		

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. Please refer to the **Humana Healthy Horizons Preauthorization and Notification Lists for Healthcare Providers** for current prior authorization lists. The services listed below may require prior authorization.

Service	Children (younger than 21)	Nonexpansion adults (21 and older)	Expansion adults (21 and older)
Applied behavioral analysis	Covered	Not covered	
Certified community behavioral health center (CCBHC) services	Covered		
Day treatment services	Covered	Not covered	
Inpatient hospital—freestanding psychiatric	Covered as medically necessary	Ages 21-64: • Covered when prior authorized in accordance with the 1115 IMD waiver. Maximum of 60 days per episode Ages 65 and older: Covered when prior authorized	
Inpatient hospital – general acute	Covered as medically necessary		
Licensed behavioral health provider (who can bill independently)	Covered	Covered	
MAT	Covered; includes: • Generic buprenorphine/naloxone sublingual tablets • Vivitrol • Methadone		
Opioid treatment programs	Covered		
Outpatient behavioral health agency services	Covered		
Partial hospitalization	Covered for a minimum of 3 hours per day for 5 days per week		

Service	Children (younger than 21)	Nonexpansion adults (21 and older)	Expansion adults (21 and older)
Peer recovery support services	Covered for ages 16-21	Covered	
Program for assertive community treatment (PACT) services	Covered for ages 18-21	Covered	
Psychiatric residential treatment facility	Covered	Not covered	
Psychiatrist	Covered		
Psychological and neurological testing	Covered		
Secure behavioral health transportation	Covered: Secure behavioral health transportation may be provided when medically necessary for the following: • Transportation to a facility including, but not limited to, hospitals and other mental health facilities • Facility-to-facility transport of a member seeking voluntary admission to a facility		
Substance use treatment (outpatient, inpatient and residential	Covered		
Targeted case management	Covered for targeted populations		
Therapeutic behavioral services, family support and training	Covered for children with serious emotional disturbance in a systems-of-care wraparound team	Not covered	
Therapeutic foster care	Covered	Not covered	

In lieu of services

In lieu of service (ILOS) is an alternative service or setting covered by Humana Healthy Horizons as a substitute or alternative to a service or setting covered under the Oklahoma Medicaid state plan. In lieu of services are medically appropriate and cost-effective substitute services that are offered voluntarily by the MCO.

Service	Benefit description	Criteria
Intensive Outpatient Behavioral Health Services	Mental health services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention; and activity therapies or education	All ages Members who are appropriate for intensive outpatient treatment must meet the MCG criteria for IOP and have a physical and emotional status that allows them to function in their usual environment; prior authorization required May be billed on a daily basis, up to 3 days per week for 9 weeks
Transcranial Magnetic Stimulation (TMS)	New non-invasive stimulation of the brain-TMS induction of a focal current in the brain and transient modulation of the targeted cerebral cortex; use for 18 and older with a diagnosis of major depression–meeting medical necessity 90867 (1 per 365 days) 90868 (limit of 36 visits in a 7 week calendar period) 90869 12-16 visits	Members aged 18 or older meeting medical necessity criteria; prior authorization required
Medically Tailored Meals (Maternal)	Up to 2 meals per day and/or medically supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.	Pregnant and postpartum females (12 weeks postpartum) deemed high risk

Cost sharing

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

Service	Copay required
Prescription drugs and insulin	Medicines on the PDL may 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 cannot be charged a copay for covered services:

- Children
- Persons receiving pregnancy-related services
- AI/AN members (when receiving services through an Indian Health Service, Tribal Health Program or Urban Indian Organization provider or pharmacy)
- 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 the provider joins the 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 providing 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 SoonerSelect Fee Schedules. These value-added benefits (VABs) 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 Healthy Horizons 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:

Additional benefits		
Benefit name	**Age limit**	**Description**
Breast pumps	All	Female members can receive 1 non-hospital grade breast pump every 2 years, or 1 rental of a hospital-grade breast pump if your baby has an inpatient stay in a NICU.
Convertible car seat or portable crib	All	Pregnant members who enroll and actively participate in our HumanaBeginnings care management program and complete a comprehensive assessment and at least 1 follow-up call with a HumanaBeginnings care manager can select 1 convertible car seat or portable crib per infant, per pregnancy.
Disaster preparedness/ relief kit	18 and older	1 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.
Healthy food produce box for food insecurity	18 and older	Up to 4 boxes of in-season nutritious fresh fruits and vegetables annually for members identified as food insecure. Plan approval required.
General Educational Development (GED) testing	16 and older	GED test preparation assistance, including 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 a test-pass guarantee to provide members multiple attempts at passing the test.
Hearing services	21 and older	• 1 assessment for hearing aids every 3 years • 1 hearing aid per ear and dispensing fee every 3 years • 2 hearing aid fitting/checking visits every 3 years • 48 batteries per hearing aid per year
Home-based interventions for asthma	All	Asthmatic members in our care management or disease management programs can receive an allowance up to $350 per year for allergen free bedding, an air purifier and/or carpet cleaning. Care manager approval required

Additional benefits		
Benefit name	**Age limit**	**Description**
Housing assistance	18 and older	Get short-term help so you can stay in your home during an emergency. This benefit provides up to $350 per year to help pay late apartment rent, trailer park lot rent, or mortgage payments. This benefit is for members 18 and older who may lose their home. Talk to your Care Manager or Humana Member Services to learn more. Plan approval required. • Member must not live in a residential facility or nursing facility • Funds are not paid directly to the member • If the bill is in the spouse's name, a marriage certificate may be submitted as proof
Native American traditional medicine	All	Reimbursement of up to $300 per calendar year for Native American members to help cover costs for Native American traditional and/or ceremonial services. Member is required to provide a signed verification form.
Disaster preparedness meals	All	1 box of 14 shelf-stable meals before or after a natural disaster, once per year • Member must not live in a residential facility. • The governor must declare the disaster for the member to be eligible for the meals.

Additional benefits		
Benefit name	**Age limit**	**Description**
Newborn care kit	0-6 months old, pregnant members, postpartum members up to 6 months after delivery, or a parent/legal guardian with a child who is a Humana member between 0-6 months old	1 newborn kit per birth Kit includes: diaper bag, diapers, wipes, diaper rash cream, baby blanket, thermometer and bulb syringe
Nonmedical transportation (NMT)- Social Needs	21 and older	Up to 15 round trips (or 30 one-way trips) up to 45 miles for NMT per year to locations such as social support groups, wellness classes, WIC and SNAP appointments and food banks. This benefit also offers transportation to locations providing social benefits and community integration for members such as community and neighborhood centers, parks, recreation areas and churches.
Non-emergency medical transportation (NEMT) – Additional passengers	All	Members using non-emergency medical transportation may be allowed to bring up to 3 children when childcare is not available. • Total number of passengers, including the driver, cannot exceed more than 5 • 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 his/her own car seat provided by the member if required by OK state law

Additional benefits		
Benefit name	**Age limit**	**Description**
Non-emergency medical transportation (NEMT) – Hospital/NICU visit	All	1 in-state round trip (2 in-state one-way trips) per day for a parent and/or guardian to visit their child during a NICU or inpatient hospital stay.
Over-the-counter (OTC) pharmacy allowance	All	Up to $30 per household per quarter allowance enables households to purchase products that support commonly occurring conditions such as: • Pain relivers • Diaper rash cream • Cough and cold relief medicine • First aid equipment that does not require a prescription • Unused amounts do not roll over to the next quarter
Parent/guardian self-care allowance	All	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.
Post-discharge meals	All	14 refrigerated home-delivered meals following discharge from an inpatient or residential facility. Limited to 4 discharges per year.
Prescription limit waived for adults	21 and older	If you are a Humana member age 21 and older, the six-prescription monthly limit does not apply. Members can receive more prescriptions when needed and there is no limit on the total number of prescriptions you may have. However, members may receive up to 2 brand-name prescriptions each month. A third brand-name prescription may be approved if your doctor says it is medically needed. For more information, please call Member Services or talk with your pharmacy. All prescriptions are still subject to state and federal requirements for Drug Utilization Review, safety edits, quantity limits and Prior Authorizations

Additional benefits		
Benefit name	**Age limit**	**Description**
Produce box for maternal care	All	To reduce access and cost barriers, Humana provides up to 4 boxes of in-season, nutritious, fresh food annually to pregnant members from their second trimester to 60 days postpartum, with Care Manager approval. Each box includes an educational pamphlet with recipes and meal ideas tailored to the specific items in the delivery. Participation in HumanaBeginnings is required.
Self-monitoring devices – blood pressure monitoring kit	21 and older	Members under care management may receive 1 digital blood pressure kit once every 3 years. Kit includes the cuff and monitor. Care manager approval required
Smartphone services	18 and older Only emancipated minors under 18 can qualify for the program	With a smartphone, you have easy access to health-related information and can stay connected to your care team and health plan. Any member who qualifies for the Federal Lifeline program will be eligible to receive a free smartphone with monthly talk minutes, text and data.
Sports physicals	6-18 years	1 sports physical per year
Tobacco and vaping cessation coaching	13 and older	The tobacco and vaping cessation program focuses on tobacco and vaping cessation coaching for members 13 and older. The program is designed as a 6-month engagement for a total of 8 coaching calls, but members have 12 months to complete the program if needed. Humana's tobacco and vaping cessation health coaching program offers support for both over the counter (OTC) and prescription nicotine replacement therapy (NRT) for members 18 and older.
Vision services	21 and older	1 annual eye exam Members can choose one of the following every 2 years: • Eyeglasses include non-high index polycarbonate lenses and a $100 allowance for the frame, or • $100 allowance for the cost of contact lenses, members are responsible for any cost over the allowance
Waived copays	21 and older	Waive copays for medical and behavioral health services

Additional benefits		
Benefit name	**Age limit**	**Description**
Youth academic support	5-18 years	Members between 5–18 years of age can receive up to 20 hours of tutoring available over a 10-week period each year; students receive targeted assistance to enhance their learning experience and excel in their studies.
Youth development and recreation	4-18 years	Member can receive reimbursement of up to $250 annually for participation in activities such as: • YMCA • 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 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, 2027, to process all 2026 claims so members have time to redeem the rewards prior to March 31, 2027. 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. Members can qualify to earn rewards by completing one or more of the following healthy activities:

Activity	Reward criteria	Reward amount
Annual wellness visit	Complete an annual wellness visit with a primary care physician (PCP). Available to members 3 years and older.	**$25 in rewards** per year
Behavioral health follow-up visit	Have a follow-up visit within 30 days after hospital discharge for behavioral health diagnosis. Available to all members.	**$25 in rewards** per year
Breast cancer screening	Get a mammogram. Available to female members 40 and older.	**$25 in rewards** per year

Activity	Reward criteria	Reward amount
Cervical cancer screening	Get a cervical cancer screening as part of a routine Pap test. Available to female members 21 and older.	**$25 in rewards** per year
Chlamydia screening	Get a chlamydia screening when sexually active or as recommended by your healthcare provider. Available to all female members.	**$25 in rewards** per year
Colorectal cancer screening	Get a colorectal cancer screening as recommended by your PCP. Available to members 45 and older.	**$25 in rewards** per year
Diabetic retinal eye exam	Get a retinal eye exam. Available to members with a diabetes diagnosis who are 18 and older.	**$25 in rewards** per year
Diabetic screening	Get an annual HbA1c and blood pressure screening with your PCP. Available to members with a diabetes diagnosis who are 18 and older.	**$25 in rewards** per year
Digital onboarding	Download the Go365 for Humana Healthy Horizons app and update communication preferences. Available to all members.	**$5 in rewards** per lifetime
Flu shot	Get the flu vaccine and, if taken from someone other than a physician or at a pharmacy, upload photo proof for documentation in the Go365 app. Available to all members.	**$20 in rewards** per year

Activity	Reward criteria	Reward amount
Health Risk Screening (HRS)	Must be completed within 30 days of enrollment in Humana Healthy Horizons. The HRS can be done in one of four ways: 1. Complete through the Go365 for Humana Healthy Horizons app, or 2. Fill out and send back the HRS in the envelope from your welcome kit, or 3. Call **855-223-9868 (TTY: 711)**, Monday – Friday, 8 a.m. – 5 p.m., Central time, or 4. Create a MyHumana account, complete and submit the HRS online. Available to all members.	**$20 in rewards** per year
High-intensity care of substance use disorder follow-up visit	Have a follow-up visit within 30 days after discharge from inpatient care, residential treatment or detoxification visit. Available to all members.	**$25 in rewards** per hospitalization
Human papillomavirus vaccine (HPV)	Must complete both doses to receive rewards. Available to members 9 to 13 years.	**$50 in rewards** per lifetime
Postpartum visit	Complete one postpartum visit within 7 to 84 days after delivery. Available to female members.	**$25 in rewards** per pregnancy
Prenatal visits	Complete up to 10 prenatal visits. Members earn $10 per visit, up to $100.Available to pregnant female members.	**$10 in rewards** per visit, up to 10 visits, max $100 per pregnancy

Activity	Reward criteria	Reward amount
Tobacco cessation incentive	Members 13 years of age and older earn $25 for completing 3 cessation sessions and another $25 for completing the full program.	**$50 in rewards** per year; $25 for completing 3 cessation sessions and $25 for completing the full program
Well-child visit (0-15 months)	Complete a wellness visit with a pediatrician. Available to members 0 to 15 months.	**$10 in rewards** per visit up to 6 visits, max $60 per year
Well-child visits (16-30 months)	Complete a wellness visit with a pediatrician. Available to members 16 to 30 months.	**$10 in rewards** per visit up to 2 visits, max $20 per year

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 **Early and Periodic Screening, Diagnostic Treatment** section of this manual for more information.

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 nontelehealth 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**. 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, and a hands-on-assessment and/or in-person care should be provided instead. Telehealth services 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 for telehealth services:

- Telehealth services and audio-only telecommunications technology must comply with 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 and 42 Code of Federal Regulations (CFR) Part 2, 45 CFR Parts 160 and 164 and 43A Oklahoma Statutes (O.S.) § 1-109.
- Telehealth visits must be completed in real time using interactive audio and video, 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 **OHCA's website**.
- 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 quality also must be sufficient. Staff must 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 or audio-only communications. 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 must 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 or audio-only communications at any time.
- Members have access to all medical records, including transmitted medical information.

For reimbursement, the telehealth service or audio-only communication must be a covered service and billed with the appropriate modifier.

In lieu of services

Humana Healthy Horizons offers other service options in lieu of services (ILOS) based on individual member needs. These include:

Intensive outpatient behavioral health services

- Mental health services: intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention and activity therapies or education
- May be billed daily, up to 3 days per week for 9 weeks
- Prior authorization required

Transcranial magnetic stimulation

- Noninvasive stimulation of the brain – transcranial magnetic stimulation (TMS) induction of a focal current in the brain and transient modulation of the targeted cerebral cortex; use for 18 and older with a diagnosis of major depression, meeting medical necessity
- Initial treatment: 1 per 365 days
- Subsequent delivery and management: 36 visits in a 7-week calendar period
- Subsequent motor threshold redetermination: 12-16 visits
- Prior authorization required

Medically tailored meals – maternal

- Members who are pregnant or 12 weeks postpartum or at high risk can receive up to 2 meals per day and/or medically supportive food and nutrition services for up to 12 weeks, or longer if medically necessary
- Care manager approval required

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. If there is a third-party liability, Humana Healthy Horizons pays claims for EPSDT services and bills the responsible third party. Humana Healthy Horizons gives providers access to tools that 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 1-, 2-, 5- and 6-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 Healthy Horizons 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 **AAP's Bright Futures website**.

Immunizations

Immunizations are an important part of preventive care for children and should be administered during well-child/EPSDT exams as needed. Humana Healthy Horizons 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 **AAP's website**.

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. Humana Healthy Horizons offers provider educational resources tailored specifically for pharmacists and medication management. For comprehensive details about pharmacy services in Oklahoma, please refer to the dedicated **pharmacy manual**.

Drug coverage

Humana Healthy Horizons and other health plans in the state are required to use a uniform PDL and UM plan developed by OHCA. The PDL includes 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 utilization management (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: Limits are placed on drugs to 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 branded drug is determined to be medically necessary, PA must be obtained.
- Quantity limits: Limits are placed to restrict the maximum quantity of a medication during a certain period, ensuring 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 were determined to be identical, similar or related
- Investigational or experimental drugs
- Agents prescribed for any indication that is not medically accepted
- Agents used for the symptomatic relief of cough and colds

PDL updates

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

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

The PDL is updated regularly, and Humana Healthy Horizons notifies providers of negative changes to the PDL. To view the current PDL and negative changes to the PDL, please visit **Humana's drug list website**. Please review the current PDL prior to writing a prescription to determine if the drug is covered. To view current medical and pharmacy coverage policies, please visit **Humana's drug list resource for providers**.

Medications administered in the provider setting

Humana Healthy Horizons covers medications administered in a provider setting, such as a provider office, hospital outpatient department, clinic, dialysis center or infusion center. Prior authorization requirements exist for many injectables. Humana Healthy Horizons may add or remove drugs on the preauthorization list (PAL) throughout the year as directed by OHCA. The current PAL can be found on **Humana's PAL website**. Medicaid providers may:

- Obtain forms at **Humana.com/MedPA**
- Submit requests by:
  - Online (preferred): Visit Covermymeds.com

  - Fax: Fax request to Humana Clinical Pharmacy Review (HCPR) Medical team at 888-447-3430.
  - Phone: Call HCPR Medical team at 866-461-7273, Monday – Friday, 7 a.m. – 10 p.m., Central time.
- View preauthorization and notification lists on **Humana's PAL website**.

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 on our **prior authorization website**
- Submit requests electronically by visiting **Covermymeds.com**
- Submit requests by fax to **877-486-2621**
- Call Humana Clinical Pharmacy Review (HCPR) at **800-555-CLIN** (**800-555-2546**)

A coverage determination decision is based on medical necessity and is communicated within 24 hours of receipt of the request from the prescriber.

Medication appeals

If Humana Healthy Horizons 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 appeal section of this manual for details on how to submit appeals.

Peer-to-peer consultations

If providers prefer to have a discussion with 1 of our pharmacists or regional medical directors before submitting an appeal, they may initiate a peer-to-peer request by calling **844-330-7734**, Monday – Friday, 7 a.m. – 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 peer-to-peer 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 Veradigm, 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 may have a $4 drug copay for members 21 and older. After the member's household meets the 5% cost-share limit, copays are waived. The following members are exempt from cost-sharing requirements and cannot be charged a copay for covered services:

- Children
- Persons receiving pregnancy-related services
- AI/AN members (when receiving services through an Indian Health Service, Tribal Health Program or Urban Indian Organization provider or pharmacy)
- Persons receiving nursing home care
- Persons receiving hospice care
- Persons in the Oklahoma Breast and Cervical Cancer Treatment Program

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. You should receive a notice of the transition event on record when your patient receives a transition claim.

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 **844-223-9868 (TTY: 711)**, Monday – Friday, 8 a.m. – 6 p.m., Central time.

Network pharmacies

Our pharmacy directory gives providers a complete list of network pharmacies that agreed to fill covered prescriptions for members. Providers and members can access our **pharmacy directory.**

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

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. United Parcel Service (UPS®) or the U.S. Postal Service delivers OTC items and other approved products 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 on **our mail order pharmacy website**. 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 controlled prescriptions. 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, 1 PCP and up to 2 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 are 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 cancer receiving chemotherapy or radiation treatment, receiving hospice care, residing in a long-term care facility, enrolled in Medicaid and Medicare programs, or who are younger than 18 are exempt from OLIP.

Chapter 10: Utilization management

Utilization management department

The utilization management (UM) department performs all utilization management activities including prior authorization, concurrent review, retrospective review, discharge planning and other related UM activities for medical and behavioral health. Humana Healthy Horizons issues and carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires. We monitor initial and continuing authorizations for 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 Care Management team are made, as needed, for members who have an identified need for complex or multi-disciplinary care. Humana Healthy Horizons completes an assessment of satisfaction with the UM process on an annual basis, identifying areas for improvement opportunities.

Utilization management 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 for covered services, appropriateness of care and service and existence of coverage and benefits. Humana Healthy Horizons does not reward providers or our staff for denying coverage or services. There are no financial incentives for Humana Healthy Horizons staff to encourage decisions that result in underutilization. Humana Healthy Horizons does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition.

Humana Healthy Horizons establishes measures designed to maintain quality of services and control costs 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 healthcare provider obtains approval from the plan as to whether an item, drug or service is covered and medically necessary.

Requests for PA should be made as soon as possible. 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 request.

Our PA list can be found on **Humana's PAL website**. Please note the PA list is subject to change. Changes to PA requirements are posted to **Humana's PAL website**. 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 at **855-223-9868**, Monday – Friday, 8 a.m. – 5 p.m., Central time, to obtain prior authorization.

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 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. 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 additional needs.
- Inpatient notification requirements: Humana Healthy Horizons requires providers to submit notification of all inpatient admissions within 1 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 services
- Family planning
- Prenatal care

- Certain behavioral health services, including:
  - Crisis services
  - MAT
  - Program for Assertive Community Treatment (PACT)
  - Urgent services

For more information, providers can access the PAL list at **Humana's PAL website**.

Requesting PA

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

- Visit **Availity Essentials** 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 on **our prior authorization webpage**.

When requesting authorization, please provide the following information:

- Member/patient name and Humana Healthy Horizons 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 Healthy Horizons clinical policies

For requests for service that are not included in the guidelines listed above, additional information a 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
- Superior Vision coverage guidelines and policies (for vision coverage criteria)
- Member and provider handbook

These guidelines 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. Clinical rationale or criteria used in making adverse UM determinations are available; requests can be made by contacting our utilization management department at:

- Email: **OKMCDUMCriteriaRequests@humana.com**
- Phone: **800-523-0023**
- Mail: Humana Correspondence
  P.O. Box 14359
  Lexington, KY 40512-4359

Criteria can also be found on **Humana's prior authorization search tool** or through the Humana Physician News newsletter **on our Physician News website**.

Time frames and notifications for responding to requests for services

- **Standard:** Notice of a decision is given as expeditiously as the member's health condition requires, but no later than 7 calendar days following receipt of the request for service.

  Expedited: When a provider indicates or Humana Healthy Horizons determines the standard review 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 authorization decision as expeditiously as the member's health condition requires but no later than 72 hours after receipt of request for services.
- **Extensions:** If the member or provider requests an extension to a standard PA request, or if Humana Healthy Horizons justifies a need for additional information and an extension is in the member's best interest, an extension period may be granted to allow up to 7 additional calendar days (for up to 14 calendar days total) to obtain the necessary documentation and to issue the notice of determination to the provider. Extension periods for Private Duty Nursing (PDN), State Plan Personal Care (SPPC), or nursing home admissions requiring Pre-Admission Screening and Resident Review (PASRR) may be granted to allow up to 14 additional calendar days to obtain the necessary documentation and to issue the notice of determination to the provider (for up to 21 calendar days total). Extensions do not apply to expedited requests. Notice of a 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.

- **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, the 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. Determinations for retrospective review requests are made within 7 calendar days of receipt.

Peer-to-peer consultations

Providers may request a peer-to-peer consultation when Humana Healthy Horizons denies a PA request or authorizes an amount, duration or scope less than requested. 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 clearly identifies 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**, fax **877-217-9199** or call **855-223-9868**. The peer-to-peer request must be made within 5 business days of notification of the determination.

Transition of care

In the best interests 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 continuity of care (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 who receive medically necessary prenatal, delivery and postnatal care through the postpartum checkup within 6 weeks of delivery

- Members who receive chemotherapy and radiation services
- Members who are undergoing dialysis
- Members who are involved with organ transplantation services
- Members who are undergoing bariatric surgery
- Members who receive Synagis® treatment
- Members who receive hepatitis C treatment and medication
- Members who receive terminal illness diagnosis
- Members who receive hemophilia services from their current hemophilia provider up to 90 days
- Members who receive behavioral health services with their current behavioral health treating provider for up to 90 days
- Members who receive durable medical equipment (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.
- Members who receive approved medication step-therapy protocols with current medications for 90 days

Children receiving private-duty nursing (PDN) services may continue to receive services during the COC period. The member can continue to receive PDN services after the COC period and indefinitely until or unless Humana Healthy Horizons completes the required Private Duty Nursing Assessment (no more than 30 days prior to the current PDN authorization redetermination date) and determines an adjustment in the authorized level of PDN services is required as a component of their overall care plan. The PDN nursing agency must continue to obtain and provide valid PDN orders and a treatment plan to maintain the authorization in 60-day increments until transition is complete. Children who receive PDN services also receive specific transition notification and assistance for those patients approaching an age that affects their coverage and eligibility.

Humana Healthy Horizons allows members with an existing relationship with a nonparticipating provider to continue to see that provider during and after the transition to Humana Healthy Horizons. Humana Healthy Horizons continues to pay a member's existing provider 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 either the provider becomes a participating provider or a participating provider 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 the next appropriate level 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 reviewer works with the PCP, the 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.

Referrals and authorization requests for personal care services must be submitted via the following:
Email: **OKMCDCaseManagement@humana.com**
Fax: **877-473-0056**
Phone: **855-223-9868**

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 an 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 of 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 a nonparticipating 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 noncovered 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 process, 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 all referrals and outcomes. 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 the 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 outside the network and facilitates 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.

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. If you have claim questions, please reach out to your **provider relations representative**.

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 6 months of the date of service or discharge and must be a clean claim. A clean claim is defined as a properly completed billing form with Current Procedural Terminology (CPT®), Fourth Edition or a more recent edition, the International Classification of Diseases, Tenth Edition, Clinical Modification (ICD-10-CM) coding or a more recent revision, or Healthcare Common Procedure Coding System (HCPCS®) coding, where applicable, that contains information specifically required, as defined in 42 C.F.R. § 447.45(b) of the Oklahoma Health Care Authority Provider Billing and Procedure Manual. Corrected claims must be submitted within 12 months of the date of service or discharge. Humana Healthy Horizons does not pay claims with incomplete, incorrect or unclear information.

Humana Healthy Horizons 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 Healthy Horizons 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.
- ICD-10-CM diagnosis code(s)
- HIPAA-compliant CPT or 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 electronic funds transfer (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 electronic remittance advice (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** (registration required).
2. From the Payer Spaces menu, select Humana.
3. From the Applications tab, select the ERA/EFT Enrollment app. (If you don't see the app, contact your Availity administrator to discuss your need for this tool.)

After filling out the EFT/ERA enrollment in Availity Essentials, the provider receives a phone call to validate the information submitted. If they miss this phone call, the provider will need to follow the instructions for EFT validation.

Instructions for EFT validation

The provider must contact the Voicemail Validation Line at **800-934-3327** and leave a message validating the enrollment request. They must provide all the following information:

- Reference/confirmation number
- TIN
- Provider name
- Caller name
- Phone number

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 also is 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:

- View 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 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 Essentials**.

For information regarding electronic claim submission, contact your local provider relations representative, visit **Humana's provider website** or log into **Availity Essentials**.

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

When filing an electronic claim, please utilize payer ID 61101 for fee-for-service claims and 61102 for encounter claims.

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

Availity Essentials	**800-282-4548**
TriZetto®	**800-556-2231**
Optum	**800-792-5256**
SSI Group	**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 5010 HIPAA-compliant transaction encounter data to OHCA via the Edifecs® system. 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 7 days of the original submission attempt. Humana Healthy Horizons also corrects and resubmits previously rejected 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 for 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 and response
- 835 electronic remittance advice
- 270/271 member eligibility
- 278 prior authorization 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. Standards currently used include these 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 (CMS)
- 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.

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 3 spaces between the NDC and the units on paper forms.

Tips for submitting paper claims:

- Electronic claims are generally processed more quickly than paper claims.
- If you submit paper claims, we require the most current 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 Social Security number 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 3 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 6 months from the date of service 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 6 months from the other insurance payment date.

Coordination of benefits

- Coordination of benefits (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 6 months 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 Healthy Horizons member ID number. Newborn infants are deemed eligible for Medicaid until 1 year old (when renewal becomes necessary) with Humana Healthy Horizons. This coverage for the mother continues for 60 days after the baby's birth. 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 and to improve patient care, reduce costs, minimize fraud, waste and abuse and retain funding, Oklahoma uses Authenticare as its EVV vendor. Home health providers can view Oklahoma EVV policy details, including Authenticare contact information, by visiting **Oklahoma's EVV website**.

Other claim requirements:

- Claim submissions for abortion, sterilization and hysterectomy procedure and initial hospice claim submissions must include the appropriately completed state or federal consent forms and/or other supporting documentation before payment can be made. The required forms can be found at **OHCA's Medicaid forms website**.
- 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 using paper form CMS-1450, also known as the UB-04. These claims are processed according to claims guidelines and processing included on **Oklahoma's EVV website**.

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 Healthy Horizons pays 90% of all clean claims submitted from providers within 14 calendar days from the date of receipt.
- Humana Healthy Horizons 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 electronic claim within 30 calendar days and for a clean paper 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 were 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 7 calendar days of the submission of the claim for both electronic and paper claims.

Humana Healthy Horizons applies 1.5% prorated monthly interest for any untimely clean claim adjudicated after 30 days of receipt for electronic claims and 45 days of receipt for paper claims. All claims must be paid within 12 months of the date of receipt except in cases of retro adjustments, investigations of fraud/abuse, or court orders.

Nothing contained in this section is intended or may be construed to alter the ability of Humana Healthy Horizons 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**. We recommend waiting 3 days after submission to check status 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**:

- Payee ("Payment To")
- Check/remit date
- Payment type (check/EFT/balance of payment [BOP])
- EFT deposit date
- Provider TIN
- Provider NPI
- Paid or denied amount and claim adjustment reason code(s)

We recommend using the remittance for full claim adjudication details.

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 Healthy Horizons entity.

Humana Healthy Horizons extends each provider the opportunity for a meeting with a Humana Healthy Horizons 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 complaint section** of this manual for additional information.

Code editing and payment policies

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

Such claim processing procedures include review of the interaction of various factors. The result of Humana Healthy Horizons' claim processing procedures is dependent on the factors reported on each claim. Accordingly, it is not feasible to provide an exhaustive description of the claim 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:
  - 2 or more surgeries performed the same day
  - 2 or more endoscopic procedures performed the same day
  - 2 or more therapy services performed the same day

- Whether a co-surgeon, assistant surgeon, surgical assistant or any other provider who is billing independently is involved
- When a claim includes more than 1 claim line, whether any service is part of, or incidental to, the primary service provided, or if these services cannot be performed together
- Whether the service is reasonably expected to treat for the reported diagnosis
- Whether a service was performed specifically for the member
- Whether services can be billed as a complete set of services under 1 billing code

Humana Healthy Horizons develops claims processing procedures at our sole discretion based on our review of correct coding initiatives, national benchmarks, industry standards and industry sources including the following, inclusive of 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
- FDA guidance
- Medical and surgical specialty societies and associations
- Industry-standard UM criteria and/or care guidelines
- Our 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 1 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. Providers can access additional information on **Humana's provider website**.

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

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

Humana Healthy Horizons provides notification of upcoming code editing changes. We publish new code editing rules and our rationales for these changes on the first Friday of each month at **Humana's claim processing edits website**.

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 policy 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 the 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 CFR 455.23. Humana Healthy Horizons ensures

that no Medicaid funds are paid to a provider whose payments are suspended or who has been terminated by OHCA.

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 calendar 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 401.305.

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.

Humana Healthy Horizons is the payer of last resort, with the following exceptions:

- Medical treatment that a member is receiving through Indian Health Services
- School-based services being received by a member who is an eligible student on an Individualized Education Program (IEP) or Individual Family Service Plan (IFSP)
- Services that a member receives that are eligible for the Crime Victims Compensation Act

Other than the exceptions listed above, if a member has coverage by an absent parent's insurance program or any other policy holder, that coverage must be used prior to Medicaid. Members must comply with the requirements of their TPL coverage as well as Humana Healthy Horizons in order to use both the TPL coverage and Medicaid. If a member does not comply with the requirements of their TPL coverage, they are responsible for the charges incurred. Please note that Medicaid's authorization that an item or service is covered under the plan, or a waiver from the plan, meets the prior authorization requirements of primary coverage.

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. If payment is denied by a member's TPL coverage, the provider must attach the EOB stating the reason for denial when they submit the claim to Humana Healthy Horizons.

If payment is received from another source, the payment amount must be reflected on the claim submission 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 is later determined that the claim should be processed first 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 in the following exceptions:

- 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 coordination of benefits (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**.

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** 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 Healthy Horizons 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 60 calendar 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 a 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 Healthy Horizons.

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 Healthy Horizons to another plan

In the event a member's enrollment ends with Humana Healthy Horizons but resumes with 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 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 Healthy Horizons

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 (6 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 the 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 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. 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 Healthy Horizons member 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 at any time, 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 within 3 days of the resolution of the grievance.

An extension may be requested by a member or a provider as an authorized representative. Humana Healthy Horizons, to the satisfaction of OHCA, on request may extend this time frame by up to 14 calendar days if more information is needed to make the decision and extending the time frame is beneficial to the member. If Humana Healthy Horizons extends the time frame but not at the request of the member, Humana Healthy Horizons will attempt to deliver prompt verbal notice of the need for an extension, a written notice, and the reason for the extension within 2 calendar days of the decision to extend the time frame. If the member disagrees with the extension, the member may file a grievance.

Appeal

The member, provider or authorized representative acting on behalf of the member, as permitted by state law, may file an appeal with Humana Healthy Horizons orally or in writing within 60 calendar days from the date on the notice of adverse benefit decision letter. 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 within 3 calendar days of the resolution of the appeal.

Humana Healthy Horizons may extend the appeal resolution time frames by up to 14 calendar days if Humana Healthy Horizons shows, to the satisfaction of OHCA, on request, that there is a need for additional information and how the delay is in the member's interest. An extension may be requested by a member or their representative. Humana Healthy Horizons attempts to deliver verbal notice of the need for an extension and we provide written notice and the reason for the extension within 2 calendar days of the decision to extend the time frame. If the member disagrees with the extension, the member may file a grievance. The member, or a provider as an authorized representative requesting the appeal, also may ask Humana Healthy Horizons for an extension.

Humana Healthy Horizons provides the member and their representative the member's case file, including medical records, other documents and records and all new or additional evidence considered, relied on, or generated by Humana Healthy Horizons (or at the direction of Humana Healthy Horizons) in connection with the appeal of the adverse benefit determination. The information must be provided free of charge and sufficiently in advance of the resolution time frame for appeals.

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 an expedited appeal. The expedited appeal must be requested within 60 calendar days of the date on the adverse benefit decision notice, and it can be requested verbally or in writing. 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.

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. If a request to process an appeal as expedited is denied, Humana Healthy Horizons attempts to provide verbal notice that the appeal will be processed within the standard resolution time frame and sends written notification within 2 calendar days.

Humana Healthy Horizons may extend the appeal resolution time frames by up to 14 calendar days if Humana Healthy Horizons shows, to the satisfaction of OHCA, on request, that there is a need for additional information and how the delay is in the member's interest. Humana Healthy Horizons attempts to deliver verbal notice of the need for an extension and provides written notice within 2 calendar days of the decision to extend the time frame. If the member disagrees with the extension, the member may file a grievance. The member or authorized representative requesting the appeal also may ask us for an extension.

Mail a member's grievance or appeal request in writing to the following address:
Humana
Attn: Grievances and Appeals Department
P.O. Box 14163
Lexington, KY 40512-4163
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 Humana Healthy Horizons fails to adhere to any timing or notice requirements as detailed in 42 C.F.R. § 438.408, the member is deemed to have exhausted the Humana Healthy Horizons appeal process and the member may initiate a State Fair Hearing, pursuant to 42 C.F.R. §§ 438.402(c)(1)(i)(A) and 438.408(f)(1)(i). If the appeal decision is not fully in the member's favor, the member, their authorized representative or the representative of a deceased member's estate can request a State Fair Hearing by contacting the Oklahoma Health Care Authority within 120 calendar days of the date on the Humana Healthy Horizons appeal decision letter.

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**

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 member files the request within 60 calendar days following the date on the Adverse Benefit Determination notice.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not yet expired.

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 1 of the following occurs:

- The member withdraws the appeal or State Fair Hearing request.
- The member fails to request a State Fair Hearing after Humana Healthy Horizons sends notice of an adverse resolution to the member's appeal.
- 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 as expeditiously as the member's health condition requires, no later than 72 hours from the date we receive notice of the favorable decision.

If the appeal or State Fair Hearing is not decided in the member's favor, the member may be liable for the cost of services received while the appeal was pending.

Chapter 13: Provider complaint system

If you are not satisfied with Humana Healthy Horizons' 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 2 internal steps:

- **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.
- **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, with their assigned provider relations representative via email or during an on-site visit. If the reconsideration request involves the outcome of a claim, providers have 6 months from the written notification receipt to submit a complaint. For dissatisfaction with policies and procedures, PPI audit findings or provider contract agreement terminations, providers are allowed 15 calendar days to submit a request for reconsideration.

Reconsideration requests are resolved within 30 calendar days of receipt of the request. Once resolved, a resolution letter is sent to the provider within 5 calendar 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 Essentials 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's training webinars webpage**.

- In person:
  Providers can submit claim reconsideration in person with their provider relations representative during an on-site visit.

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, Suite 2800
Oklahoma City, OK 73102

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

Formal appeals

If you are dissatisfied with the determination of the reconsideration request related to claims 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 of 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. Please refer to the **Grievances and Appeals** section of this manual.
- A resolution letter is mailed within 5 calendar days of determination of the appeal.

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

Providers can mail an appeal in writing to:
Humana Healthy Horizons in Oklahoma Provider Appeals
210 Park Ave, Suite 2800
Oklahoma City, OK 73102

Providers can send an appeal via email to **OKMedicaidProviderRelations@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 of the appeal determination date. 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 Healthy Horizons 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 who 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 Healthy Horizons, 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 Healthy Horizons 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 Healthy Horizons 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 facilities that describe 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 Healthy Horizons, 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 1 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 all information necessary to monitor provider performance on an ongoing and periodic basis, including performance data for quality improvement activities
- Send electronic patient 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 training
- 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 within our network 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, 7 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 7 calendar days from the date of discharge.
- 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 of 1986 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 Healthy Horizons 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. 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, per OAC 317:30-3-13(a)(3) and 42 CFR 422.128(b)(1)(ii)(E).

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, as per 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). The advance directive becomes effective when it is communicated to the provider and the member is no longer able to make decisions regarding administration of life-sustaining treatment, in accordance with 63 O.S. § 3101.5. Providers cannot administer care conditionally and cannot discriminate against the member based on whether or not they have executed an advance directive, per OAC 317:30-3-13(a)(4).

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.

An advance instruction for behavioral health treatment is a legal document that informs providers of what mental health treatments the member would and would not want if they later became unable to decide for themselves. Members also can use it to nominate a person to serve as guardian if guardianship proceedings are started. An advance instruction for behavioral health treatment can be a separate document or combined with a healthcare power of attorney or a general power of attorney. A provider can follow an advance instruction for behavioral health if the provider or an eligible psychologist determines in writing that the member is no longer able to make or communicate behavioral health decisions.

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, 7 days a week when medically necessary. An after-hours PCP telephone number must be available to members. Voicemail is not permitted.

The Humana Healthy Horizons 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 pediatric PCP	Urban distance	Within 10 miles of a Humana Healthy Horizons member's residence
Adult and pediatric PCP	Rural distance	Within 30 miles of a Humana Healthy Horizons member's residence

Provider type	Measure	Standard
Appointment time		
Adult and pediatric PCP	• Not to exceed 30 days from date of the Humana Healthy Horizons member's request for routine appointment • Within 72 hours for nonurgent 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 Healthy Horizons member's residence
OB-GYN	Rural distance	Within 45 miles of a Humana Healthy Horizons member's residence
Appointment time		
OB-GYN	• Not to exceed 30 days from date of the Humana Healthy Horizons member's request for routine appointment • Within 72 hours for nonurgent sick visits • Within 24 hours for urgent care Maternity care: • First trimester – Not to exceed 14 calendar days • Second trimester – Not to exceed 7 calendar days • Third trimester – Not to exceed 3 business days	
Provider type	**Measure**	**Standard**
Distance		
Adult specialty Pediatric specialty	Urban distance	Within 15 miles of a Humana Healthy Horizons member's residence
Adult specialty Pediatric specialty	Rural distance	Within 60 miles of a Humana Healthy Horizons member's residence
Appointment time		
Adult specialty Pediatric specialty	Not to exceed 30 days from date of the Humana Healthy Horizons 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		
• **Adult and pediatric mental health** • **Adult and pediatric substance use**	Urban distance	Within 10 miles of a Humana Healthy Horizons 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 Healthy Horizons member's residence for outpatient visits Within 90 miles of a Humana Healthy Horizons 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 Healthy Horizons 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 5-digit ZIP code in which the population density is greater than 3,000 individuals per square mile	At least 90% of Humana Healthy Horizons members reside within 2 miles of a retail pharmacy participating in the PBM's retail pharmacy network
	Suburban service area, meaning a 5-digit ZIP code in which the population density is between 1,000 and 3,000 individuals per square mile	At least 90% of Humana Healthy Horizons members reside within 5 miles of a retail pharmacy in the PBM's retail pharmacy network
	Rural service area, meaning a 5-digit ZIP code in which the population density is less than 1,000 individuals per square mile	At least 70% of Humana Healthy Horizons 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 Healthy Horizons member's residence
Essential community providers	Rural distance	Within 45 miles of a Humana Healthy Horizons member's residence
Appointment time		
Essential community providers	Not specified	
Provider type	**Measure**	**Standard**
Distance		
Hospitals	Urban distance	Within 10 miles of a Humana Healthy Horizons member's residence
Hospitals	Rural distance	Within 45 miles of a Humana Healthy Horizons 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 Healthy Horizons, 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 Healthy Horizons may post general nonadvertising 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 entails 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])
- 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.

Before requesting to join a managed care entity (MCE) network, providers must first be contracted and enrolled with OHCA. You can begin the process at the **SoonerCare provider enrollment website**.

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: **OKProviderDevelopment@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 victims of abuse, neglect or exploitation to the appropriate state agency within 24 hours of the incident taking place and action must be taken immediately or within 24 hours of the incident. PRFT providers should email facility critical incident reports to **OKMCDCriticalIncidents@humana.com**.

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

- **Abuse** – Nonaccidental 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 in which 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 they wish and have a right to abstain, or to refrain from conduct in which they wish and have 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; includes, but is 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, they also receive identity protection.

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

Critical incident reporting

When a member 21 years or younger is in the care of a contracted Psychiatric Residential Treatment Facility (PRTF), critical incidents can include, but are not limited to, the following, in accordance with OAC 317:30- 5-95.39:

- Suicide
- Non-suicidal death
- Death by unknown causes
- 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

PRTF providers are required to report adverse or critical incidents to Humana Healthy Horizons by email at **OKMCDCriticalIncidents@humana.com**, 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 Provider Services contact center: **855-223-9868**
- OHCA Behavioral Health Unit: **800-522-9054**
- Oklahoma Department of Human Services: **405-522-5050**

PRTF 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. PRTF 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 3 days from a 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 PRTF's report and follows up with the PRTF 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 asked to report domestic abuse incidents by adult victims with legal capacity must promptly report to the nearest law enforcement agency, per 22 O.S. 58.

Americans with Disabilities Act

All Humana Healthy Horizons-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 Healthy Horizons 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 the needs of all members, including those with physical and nonphysical disabilities
- Use of clear signage throughout provider offices
- Provision of adequate handicapped parking

Humana Healthy Horizons' 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 **Humana's accessibility resources website** 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 Healthy Horizons network
- Provide clear explanation of Humana Healthy Horizons program policies to ensure compliance
- Provide useful tools, resources and educational materials on how to do business with Humana Healthy Horizons, 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

A listing of our training can be found on our **provider resources** website. Providers also can sign up for newsletters **on our website**.

Required compliance-based training programs

Providers must adhere to all Humana Healthy Horizons-identified compliance-based training programs and requirements outlined in the Humana Healthy Horizons 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 Healthy Horizons 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 Healthy Horizons' contract with OHCA and/or Humana Healthy Horizons policies:

- **Humana Healthy Horizons in Oklahoma new provider orientation** — Humana Healthy Horizons 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**
- **Addressing fraud, waste and abuse**
- **Ethics Everyday training**

Humana Healthy Horizons 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 Healthy Horizons reserves the right to request evidence at any time that 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 FWA, please see the **fraud, waste and abuse policy chapter** of this manual.

Compliance requirements should be completed within 30 days of notification.

Completing your compliance training and attestation online

Training is available through Availity Essentials:

1. Once logged in to **Availity Essentials**, click on Payer Spaces > Humana > Humana Learning Center
2. Select the category: Compliance training
3. Search for the current year training by state (for any state(s) in which you are contracted)

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

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

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

Chapter 16: Member rights and responsibilities

Member rights

Humana Healthy Horizons members have the right to:

- Receive information on the Humana Healthy Horizons program, its services, its providers and member rights and responsibilities
- Be treated with respect and with due consideration for their dignity and privacy
- Have a discussion and receive information about available treatment options and alternatives in a way the member understands, regardless of cost or benefit coverage
- 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
- Voice complaints or appeals about Humana Healthy Horizons or the care it provides
- Make recommendations about the member rights and responsibilities policy

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.
- Respond to requests for assistance from the Oklahoma Human Services (OHS) 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
- Supply information (to the extent possible) that Humana Healthy Horizons and its providers need to provide care
- Follow plans and instructions for care that they have agreed to with their provider
- Understand their health problems and participate in setting agreed-on goals, to the degree possible

Chapter 17: Cultural competency

Understanding cultural competency

Humana Healthy Horizons recognizes cultural differences and the influences that 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 addressing 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.

Enhancing cultural competency

To enhance cultural competency, providers should:

- 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.
- Attend cultural competence training at your organization or through a continuing education program in addition to completing the required Humana Healthy Horizons Cultural Competency training.
- 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 can often 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 and individuating 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: the 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: the 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 believe they are trying to communicate 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

The Humana Healthy Horizons 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 health care 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 Healthy Horizons' 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 the Humana Healthy Horizons 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 health care
- 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. These 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 **Humana's Clinical Practice Guidelines for Healthcare Providers website**.

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 member's identifying information, including name, member's identification number, date of birth, sex/gender identification, responsible party (parent or legal guardianship, as applicable), phone number, race and place of residence.
- **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 3 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. For pediatric patients, past medical history includes prenatal care and birth information and childhood illnesses (members 11 and younger.)

- **Physical exam (complete):** All body systems should be reviewed within 1 year 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.
- **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:** Preventive screenings should be offered or referred. 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 X-ray, lab and 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 3 or more times, 12 years and older, a notation concerning tobacco use must be present.
- **Alcohol:** For patients seen 3 or more times, 12 years and older, a notation concerning alcohol use must be present.
- **Substance use:** For patients seen 3 or more times, 12 years and older, a notation concerning substance use must be present.
- **Immunization record:** A current record of immunizations should appear in the patient chart.
- **Advance directives:** As recognized by Oklahoma law, for patients 18 and older only, there should be evidence the patient was asked if they have an **advance directive** (written directions about healthcare decisions) and a yes or no response should be documented. If the response is yes, a copy of the advance directive must be included in the medical record.
- **Prescribed medications:** All current medications, including dose and date of initial prescription or refills, should be present in the medical record. Long-term medications should be reviewed and reconciled.

- **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 2 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 supplemental 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, electronic medical record [EMR]) to another without manual interpretation. Therefore, standard supplemental data is exempt from audit consideration. Standard supplemental data can be accepted via HEDIS-specific custom reports extracted directly from the provider's EMR or population health tool and 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 EMR vendors 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 the 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 the 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 the 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 who meet 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 1 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 regarding 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 who 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 **855-223-9868** 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** (24/7 access)
- Ethics Help Line: 877-5-THE-KEY (**877-584-3539**)

Email:

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

Online:

- **Ethicshelpline.com** or **Humana Special Investigations Referral Form**

Chapter 20: Credentialing and recredentialing

Effective July 1, 2025, all providers participating in SoonerSelect health plans are required to submit credentialing and recredentialing applications, including all supporting documentation, through a centralized online portal: the Availity Essentials™ portal.

Single submission process: Providers will submit credentialing applications and supporting documents once through the Availity Essentials portal. This centralized system grants all SoonerSelect health plans access to the submitted information, eliminating the need for multiple submissions. Additionally, providers can conveniently track the status of their credentialing directly within the portal.

Credentialing module access: Providers will have access to a dedicated credentialing module within the Availity Essentials SoonerSelect portal. Creating an account and completing an application is free.

New to Availity Essentials? Start your journey here: **Register and Get Started with Availity Essentials – Overview.**

Already a registered Availity user? Log in here: **Availity Essentials**.

Collaboration across MCEs: SoonerSelect health plans will refer providers to the Availity Essentials portal, accept the credentialing information submitted to the Availity Essentials portal, and work collaboratively to align credentialing and recredentialing processes across all SoonerSelect plans.

Credentialing calendar for SoonerSelect-only providers: Providers currently contracted with the health plans solely for SoonerSelect will follow a single, common credentialing calendar based on OHCA's provider type. Credentialing will occur over a 12-month period. Please refer to the credentialing calendar to anticipate when credentialing will be complete.

Credentialing for existing providers: Providers contracted for the Humana Healthy Horizons network and already credentialed by Humana for another line of business (e.g., Medicare Advantage) will share a credentialing record. No additional action is required unless further information is specifically requested by the health plan to fulfill an OHCA requirement. Existing recredentialing dates will remain unchanged, and providers may continue to use CAQH ProView® to complete their recredentialing application.

SoonerSelect health plans cannot issue a credentialing decision until the provider has completed the OHCA contracting and enrollment process. The credentialing approval date must not precede the OHCA enrollment date. You can begin the process at the **Provider Enrollment home.**

Humana will process credentialing requests for all provider types within 45 calendar days of receipt of a completed credentialing application, including all required documentation, attachments and a signed provider agreement. Humana may request a 15-calendar day extension from OHCA on a case-by-case basis.

Any provider appearing in the provider directory must complete the Humana Healthy Horizons credentialing process.

Practitioner credentialing and recredentialing

Practitioners subject to MCE credentialing include, but may not be limited to the following medical practitioners:

- Audiologists
- Board certified behavior analysts (BCBAs)
- Certified nurse midwives
- Chiropractors
- Diabetic educators
- Genetic counselors
- Medical doctors
- Nurse practitioners
- Optometrists
- Oral maxillofacial surgeons
- Oral surgeons
- Osteopaths
- Pharmacists
- Physical and occupational therapists and speech and language pathologists
- Physician assistants
- Podiatrists
- Other medical practitioners who may be within the scope of credentialing and who are licensed, certified or registered by the state to practice independently or as required by state regulations. This category includes:
  - Board-certified assistant behavior analyst (BCABA)
  - Doula
  - Early intervention service provider
  - Lactation consultant
  - Occupational therapy assistant
  - Physical therapy assistant
  - Registered behavior technician (RBT)
  - Respiratory therapist
  - Speech-language pathology assistant
  - Speech-language pathology clinical fellow

Behavioral health practitioners:

- Doctoral or master's level psychologists who are state licensed
- Licensed behavioral practitioners (LBPs)
- Licensed clinical addiction counselors (LCACs)
- Master's level clinical nurse specialists or psychiatric nurse practitioners who are state licensed
- Master's level clinical social workers (LCSWs) who are state licensed
- Master's level licensed marriage and family therapists (LMFTs) who are state licensed
- Master's level professional counselors (LPCs) who are state licensed
- Physician assistants – behavioral health
- Psychiatrists and other physicians
- Other behavioral health practitioners who may be within the scope of credentialing and who are licensed, certified or registered by the state to practice independently or as required by state regulations. This category includes:
  - Behavioral health case managers
  - Case managers and care coordinators, including:
    - Behavioral health case manager I
    - Behavioral health case manager II
    - Behavioral health rehabilitation specialist, bachelor's level
    - Care coordinator for pregnant people
    - HIV case manager
    - Intensive case manager
  - Certified alcohol and drug counselors (CADCs), bachelor's level
  - Family support and training providers
  - Licensed practical nurses (LPNs)
  - Licensure candidates
  - Peer recovery support specialists
  - Registered nurses, bachelor's level

Organizational credentialing and recredentialing

Organizational providers subject to Humana Healthy Horizons credentialing include, but are not limited to, the following:

- Adult day cares (Oklahoma Complete Health [OCH] only)
- Ambulatory surgical centers
- Clinics, including:

  - Federally qualified health centers (FQHCs)
  - Rural health clinics (RHCs)
  - Therapy (PT/OT/SLP) organizations
  - Urgent care centers
- Dialysis centers/end-stage renal disease (ESRD) clinics
- Durable medical equipment (DME)/home medical equipment (HME) providers
- Foster care agencies (OCH only)
- Free standing birthing centers
- Hearing-aid dealers
- Home health agencies
- Homemaker services (OCH only)
- Hospice providers
- Hospitals
- Indian Health Care Providers/tribal facilities
- Laboratories
- Mobile X-ray clinics/freestanding X-ray clinics
- Outpatient physical therapy and speech pathology facilities
- Personal care services
- Pharmacies
- Providers of outpatient diabetes self-management training
- Public health agencies
- Rehabilitation facilities/comprehensive outpatient rehabilitation facilities (CORF)
- Respite care (OCH only)
- Skilled nursing facilities (SNFs)/extended care facilities
- Transportation

Behavioral health care facilities providing mental health or substance use services in settings described below are subject to MCO credentialing. These facilities include, but are not limited to, the following:

- Ambulatory
- Inpatient
- Outpatient
- Residential/extended care facilities

School-based provider assessment

School-based providers must complete the credentialing process through the Oklahoma State Department of Education (OSDE) and be contracted with OHCA before joining an MCO's provider network.

Behavioral health providers under supervision must have a master's degree and be under active supervision approved by the licensing board. The following provider types fall under the OSDE credentialing scope when practicing in a school-based setting:

- Licensed behavioral practitioner (LBP)
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed practical nurse (LPN) under the supervision of an RN
- Licensed professional counselor (LPC)
- Licensed psychologist
- OSDE-certified school psychologist (must be an employee of the district)
- Paraprofessional, contracted by OHCA as school-based paraprofessional
- Physical and occupational therapist and assistant
- Registered nurse (RN)
- Speech and language pathologist/therapist and assistant

You can find more information related to school-based provider enrollment on the OHCA school-based services website.

Provider rights in credentialing

Providers have the right to review, on request, information submitted to support their credentialing application to the Humana Healthy Horizons Credentialing department. Humana Healthy Horizons keeps all submitted information 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.

Nondiscrimination in credentialing and recredentialing

Humana Healthy Horizons does not make credentialing decisions based on an applicant's race, ethnic/national identity, gender, age or sexual orientation or on type of procedure or patient in which a practitioner or organizational provider specializes. Humana Healthy Horizons does not discriminate against a provider based on the practitioner's license or certification or because the provider serves high-risk populations and/or specializes in the treatment of costly conditions.

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 Healthy Horizons delegated entities (delegate). The policies in the Humana Healthy Horizons in Oklahoma 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 Healthy Horizons delegates to an entity.

Oversight

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

The delegation process begins with Humana Healthy Horizons performing a predelegation audit prior to any function being delegated to a prospective entity. After approval and an executed delegation agreement, Humana Healthy Horizons performs an annual audit on an ongoing basis until the delegation agreement is terminated.

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

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

Humana Healthy Horizons continues to monitor all delegated entities through the collection of periodic reporting. The delegate must submit all required reporting for all delegated functions as outlined within the delegation agreement. Humana Healthy Horizons provides the templates and

submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or updated Humana Healthy Horizons 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 Healthy Horizons requirements, federal and state laws, rules, regulations or NCQA accreditation 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 found to be noncompliant, including the expected remediation date of compliance.

Humana Healthy Horizons 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 Healthy Horizons for the development of a CAP may result, at the discretion of Humana Healthy Horizons, in the immediate suspension or revocation of all or any portion of the functions and activities delegated. This includes withholding a portion of the reimbursement or payment under the contract agreement.

Subdelegation

The delegate must have Humana Healthy Horizons' prior written approval for any subdelegation by the delegate of any functions and/or activities and notify Humana Healthy Horizons of changes to functions being delegated including any offshore locations. The delegate must provide Humana Healthy Horizons with documentation of the predelegation audit that the delegate performed of the subcontractor's compliance with the functions and/or activities to be delegated.

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

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

- Is mutually agreed on
- Describes the activities and responsibilities of the delegate and the subdelegate
- Requires at least semiannual reporting of the subdelegate to the delegate
- Describes the process by which the delegate evaluates the subdelegate's performance
- Describes the remedies available to the delegate if the subdelegate does not fulfill its obligations, including revocation of the delegation agreement
- Allows Humana Healthy Horizons access to all records and documentation pertaining to monitoring and oversight of the delegated activities
- Requires the delegated functions to be performed in accordance with Humana Healthy Horizons' and the delegate's requirements, state and federal rules, laws, regulations and accreditation

organization standards and subject to the terms of the written agreement between Humana Healthy Horizons and the delegate

- Retains Humana Healthy Horizons' 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 Healthy Horizons with documentation of such oversight prior to delegation and annually thereafter. Humana Healthy Horizons retains the right to perform additional evaluation and oversight of the subcontractor, if deemed necessary by Humana Healthy Horizons. Furthermore, Humana Healthy Horizons retains the right to modify, rescind or terminate, at any time, any 1 or all delegated activities, regardless of any subdelegation previously approved.

Delegates must agree 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 the 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 Healthy Horizons members.

Delegation requirements

The delegate must comply with the following requirements:

- Submit any material change in the performance of delegated functions to Humana Healthy Horizons for review and approval prior to the effective date of the proposed changes.
- Obtain and maintain, in good standing, a third-party administrator license/certificate and/or a utilization review license or certification if required by state and/or federal law, rule or regulation.
- Ensure that personnel who carry out the delegated services have appropriate training, licensure and/or certification.
- Adhere to Humana Healthy Horizons' record retention policy for all delegated function documents, which is 10 years.
- Use Humana Healthy Horizons member templates for all member communications. Delegate must implement any updates to templates within 30 calendar days of notification of updates from Humana Healthy Horizons.
- Comply with requirements to issue member denial and approval letters in the member's preferred language if required by state laws, rules or regulations.

UM delegation requirements

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.

All delegates performing UM activities must comply with and meet the rules and requirements for processing UM requests established or implemented by the state. In addition, they must conduct all UM activities in accordance with NCQA accreditation standards, the member's plan and Humana Healthy Horizons' policies and procedures.

Humana Healthy Horizons retains the right and final authority to approve or deny UM decisions for its members regardless of any delegation of such functions or activities to delegate. Refer to your delegation agreement for specifics.

The delegate must conduct the following functions regarding initial and expedited/urgent determinations:

- Maintain policies and procedures that address all aspects of the UM process including a member's right to a second opinion
- Formally review, revise, date and sign policies and procedures annually. Effective dates are present on policies or on a policy master list
- Agree not to have a more stringent PAL than Humana Healthy Horizons' PAL, which is posted on **Humana's PAL website**. If the delegate is delegated for both UM and claims payment, the delegate may develop their own PAL. However, the delegate's PAL may not be more stringent than Humana Healthy Horizons' PAL
- Perform preadmission review and authorization, including medical necessity determinations based on approved criteria, specific benefits and member eligibility
- Perform UM activities for outpatient/ambulatory care
- 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 Healthy Horizons does not delegate quality-of-care determinations
  - Provide continued stay determinations and maintain a denial log for submission to Humana Healthy Horizons as directed
  - Notify the member, facility and provider of a decision on a concurrent determination
- Perform retrospective reviews, UM activities for out-of-service areas and out-of-network providers, and discharge planning as dictated by the contract
- Use Humana Healthy Horizons' step-therapy preauthorization list when implementing a step-therapy regimen
- Notify the member, facility and provider of a decision on an initial determination
- Maintain documentation of pertinent clinical information gathered to support the determination
- Understand that all UM files and supporting documentation are the property of Humana Healthy Horizons. Should the contract between the delegate and Humana Healthy Horizons be dissolved

for any reason, the delegate is expected to make available to Humana Healthy Horizons either the original or quality copies of all UM files for Humana Healthy Horizons members

Population health management delegation requirements

All delegates performing population health management (PHM) must conduct PHM activities in accordance with NCQA standards, including:

- **Complex case management (CCM)**
  - CCM is coordination of care and services provided to members who experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.
- **Disease management (DM)**
  - DM is a multidisciplinary, continuum-based approach to healthcare delivery that proactively identifies populations with, or at risk for, established medical conditions.

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

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 Healthy Horizons' policies and procedures. Delegates need to meet, at a minimum, the following claims adjudication and processing requirements:

- The delegate must make correct claims determinations and process all claims in accordance with state and federal prompt pay requirements to which Humana Healthy Horizons is subject.
- The delegate must pay any and all interest amounts on claims in accordance with applicable state and federal requirements.
- The delegate must maintain an accuracy rate of 99% of total dollars paid for any given calendar month.
- The delegate must notify the member, facility and provider of any claims that have been denied.
- The delegate should forward all nonparticipating reconsideration requests to Humana Healthy Horizons on receipt.
- The delegate must provide a financial guarantee, acceptable to Humana Healthy Horizons, such as a letter of credit, to ensure its continued financial solvency and ability to adjudicate and process

claims. The delegate must submit appropriate financial information on request as proof of its continued financial solvency.

- The delegate must submit claim/encounter data in the format defined in the Process Integration Attachment or as required by the state.
- The delegate must make available as requested by Humana Healthy Horizons all original files, records and documentation pertaining to Humana Healthy Horizons members, or copies thereof on the termination of the performance of delegated functions and/or the expiration, nonrenewal or termination of the agreement, regardless of the cause.

Credentialing delegation requirements

All delegates performing credentialing and recredentialing activities must comply with and meet the rules and requirements established or implemented by the state. In addition, they must conduct all credentialing and recredentialing activities in accordance with NCQA accreditation standards and Humana Healthy Horizons' policies and procedures. This includes maintaining a credentialing committee, a credentialing and recredentialing program and all related policies, procedures and processes in compliance with these requirements.

Humana Healthy Horizons is responsible for the collection and evaluation of ongoing monitoring of sanctions and complaints. In addition, Humana Healthy Horizons retains the right to approve, deny, terminate or suspend new or renewing practitioners and organizational providers from participation in any of 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 Healthy Horizons. Delegate should, at a minimum, include the following elements in credentialing reports to Humana Healthy Horizons:

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

Appeals and grievances

Humana Healthy Horizons member appeals/grievances and expedited appeals processes are not delegated, including any appeal made by a physician/provider on the member's behalf, except clinical decision making in certain special circumstances.

Therefore, the delegate must:

- Forward all standard member appeals/grievances to Humana within 1 business day by calling **855-223-9868** or faxing **800-949-2961**.
- Forward all expedited appeals immediately on notification/receipt by calling **855-223-9868** or faxing **800-949-2961**.
- Provide the following information when forwarding member appeals or grievances: date and time of receipt, member information, summary of the appeal or grievance, all denial information, if applicable and summary of any actions taken, if applicable.
- Promptly effectuate the appeal decision as rendered by Humana Healthy Horizons and support any requests received from Humana Healthy Horizons in an expedited manner.
- Handle all participating physician, provider, hospital and other healthcare professional provider claim payments and payment denial disputes. Humana Healthy Horizons handles all nonparticipating physician, practitioner, hospital and other healthcare professional provider claim payments and payment denial disputes or requests for reconsiderations.

Definitions

Audio-only health service delivery – The delivery of healthcare services through the use of audio-only telecommunications, permitting real-time communication between a patient and the provider, for the purpose of diagnosis, consultation and/or treatment. Audio-only health service delivery does not include the use of facsimile, email, or health care services that are customarily delivered by audio-only telecommunications and not billed as separate services by the provider, such as the sharing of laboratory results. This definition includes health services delivered via audio-only when audio-visual is unavailable or when a member chooses audio-only.

Behavioral health emergency – A situation in which a member presents an 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, existing PAs and care plans shall remain in place.

Contract – A result of receiving an award from OHCA and successfully meeting all readiness review requirements, the agreement between Humana Healthy Horizons and OHCA where Humana Healthy Horizons will provide Medicaid services to SoonerSelect members, comprising of 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 services 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. This includes an accountable care organization, a provider led entity, a Commercial Plan, a dental benefit manager 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 has been deemed eligible for the SoonerSelect program but who is not enrolled in Humana Healthy Horizons.

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 – Medical services provided for a medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organs or parts.

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 – Any service provided by a participating provider, or by an individual working for or under the supervision of the participating provider, that relates to the diagnosis, assessment, prevention, treatment, or care of any human illness, disease, injury, or condition. Unless the context clearly indicates otherwise, health care service includes the provision of mental health and substance use disorder services and the provision of durable medical equipment.

Health risk screening – A screening tool developed by Humana Healthy Horizons 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 – Services or supplies provided by a participating provider that are:

a. Appropriate for the symptoms and diagnosis or treatment of a member's condition, illness, disease or injury

b. In accordance with standards of good medical practice

c. Not primarily for the convenience of the member or the member's health care provider, and

d. The most appropriate supply or level of service that can safely be provided to the member as determined by the authority

Member – An individual who has been deemed eligible for Medicaid in the state of Oklahoma, who has been deemed eligible for enrollment in the SoonerSelect program, and/or is currently enrolled in the SoonerSelect program.

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.

Nonparticipating 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.

Nonurgent Sick Visit – Medical care given for an acute onset of symptoms which is not emergent or urgent but requires face-to-face medical attention within 72 hours of member notification of a nonurgent condition, as clinically indicated. Examples of nonurgent sick visits include cold symptoms, sore throat and nasal congestion.

Oklahoma Health Care Authority (OHCA) – 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. 3 major service branches, Community & Family Health Services, Prevention & Preparedness Services and Protective Health Services provide technical support and guidance to 68 county health departments as well as guidance and consultation to the 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 Healthy Horizons to provide services to members under the SoonerSelect program.

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 activities of daily living, 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 – Includes the following:

a. Family medicine physicians in an outpatient setting when practicing general primary care
b. General pediatric physicians and adolescent medicine physicians in an outpatient setting when practicing general primary care
c. Geriatric medicine physicians in an outpatient setting when practicing general primary care
d. Internal medicine physicians in an outpatient setting when practicing general primary care (excludes internists who subspecialize in areas such as cardiology, oncology and other common internal medicine subspecialties beyond the scope of general primary care)
e. Obstetrics and gynecology physicians in an outpatient setting when practicing general primary care
f. Provider types that include nurse practitioners and physicians' assistants in an outpatient setting when practicing general primary care
g. Behavioral health providers, including psychiatrists, providing mental health and substance use disorder services when integrated into a primary care setting

Prior authorization – The process by which a contacted entity or its designee utilization review entity determines the medical necessity and medical appropriateness of otherwise covered health care services prior to the rendering of such healthcare services.

Protected Health Information – Information considered to be individually identifiable health information, per 452 C.F.R. § 160.103.

Provider – Includes both participating and nonparticipating providers.

Provider Agreement – An agreement between Humana Healthy Horizons and a participating provider that describes the conditions under which the participating provider agrees to furnish covered health care 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 Humana Healthy Horizons quality metrics.

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.

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 – The contracted entities with whom OCHA contracts to provide SoonerCare covered medical, dental, pharmacy and behavioral health benefits.

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 healthcare 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 healthcare 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 or dental 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 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
c. A serious dysfunction of any body organ or part

Value-added benefit – Any benefit or service offered by Humana Healthy Horizons when that benefit or service is not a covered benefit per the State Plan. These benefits are subject to change annually as determined by Humana Healthy Horizons and OHCA.

Visit – A face-to-face encounter between a clinic patient and a physician, physician assistant (PA), advanced practice registered nurse (APRN), certified nurse midwife (CMN), clinical psychologist (CP) or clinical social worker whose services are reimbursed under the rural health clinic prospective payment system payment method. Encounters with more than 1 healthcare professional and multiple encounters with the same healthcare professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Services delivered via audio-only telecommunications and reimbursed pursuant to the fee-for-service fee schedule do not constitute a visit and/or an encounter.

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/Alaskan 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 health care 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	non-emergency 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
US/U.S.	United States
VAB	value-added benefit