Humana Healthy Horizons in South Carolina Behavioral Health Quick Reference Guide

Humana
Healthy Horizons®
in South Carolina

Healthy Connections

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

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Behavioral health and substance use services

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

Humana Healthy Horizons provides a comprehensive range of basic and specialized behavioral health services. Basic behavioral health services are provided through primary care and include, but are not limited to, mental health and substance use issue screenings, prevention, early intervention, medication management, treatment and specialty service referrals.

Specialized behavioral health services include, but are not limited to:

- Inpatient hospitalization for behavioral health services
- Outpatient and residential substance use disorder services in accordance with American Society of Addiction Medicine (ASAM) levels of care
- Medication-assisted treatment, including buprenorphine and naltrexone, available in multiple settings including residential settings
- Crisis management: Services provided to an individual experiencing a psychiatric crisis that are designed to interrupt and/or ameliorate a crisis experience through a preliminary assessment, immediate crisis resolution, de-escalation, and referral to and connection with appropriate community services
- Applied behavioral analysis therapy (younger than 21): The design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior
- Licensed practitioner outpatient therapy which includes, but is not limited to:
  - Individual, family, group and multi-family group psychotherapy
  - Assessment and screening
  - Psychological evaluation and testing
  - Medication management
  - Psychological evaluation and treatment
  - Medication administration
  - Individual therapy with medical evaluation, management and case consultation
  - Service plan development
- Community support services, which include the following (prior authorization required):
  - Psychosocial rehabilitation services (PRS)
  - Behavior modification (B-MOD), available up to age 21
  - Family support (FS), available for families of children up to age 21
  - Therapeutic childcare (TCC), available up to age 6
  - Community integration services (CIS), available to adults with severe and persistent mental illness (SPMI)/substance use disorder (SUD)
  - Peer support services (PSS), to be rendered only by Department of Mental Health (DMH) and Department of Alcohol and Other Drug Abuse Services (DAODAS) providers

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

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

Behavioral health screening and evaluation

Humana Healthy Horizons requires network primary care providers (PCPs) receive the following training:

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

Continuation of behavioral health treatment

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

Referrals for release due to ethical reasons

Humana Healthy Horizons providers are not required to perform treatments or procedures that are contrary to the provider's conscience, religious beliefs or ethical principles, in accordance with 42 C.F.R. 438.102. Providers should notify Humana Healthy Horizons of treatments or procedures they won't provide due to ethical reasons by emailing **SCBHMedicaid@humana.com**.

This email address also can be used for general behavioral health inquiries. Providers also may call **866-432-0001** for assistance.

Managed care organizations (MCOs) are responsible for the full array of behavioral health services set forth in the following manuals:

- Autism spectrum disorder provider manual
- Hospital services provider manual
- Licensed independent practitioner's provider manual
- Psychiatric residential treatment services located in the psychiatric hospital services provider manual
- Clinic services manual
- Physicians, laboratories and other medical professionals provider manual
- Rehabilitative behavioral health services provider manual
- Community mental health clinics

These manuals can be found at South Carolina Department of Health and Human Services' website.

School-based services

In accordance with the South Carolina Department of Health and Human Services (SCDHHS) School-based Mental Health Initiative, effective July 1, 2022, rehabilitative behavioral health services (RBHS) can be delivered in school settings by Humana Healthy Horizons master's-level behavioral health providers who are contracted by the school district. Providers are advised to review the recently updated SCDHHS Local Education Agencies (LEA) Services Provider Manual, the LEA school-based services alternative fee schedule and frequently asked questions (FAQ) document on the SCDHHS website for full details.

Services, effective July 1, 2023

Assertive Community Treatment (ACT)

- H0040 with modifier U1
- H0040 with modifier U3

Autism

- 97154 – Limit six hours per day, performed by registered behavioral technician (RBT)
- 97158 – Limit six hours per day, performed by board certified behavior analyst (BCBA)

Claims

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

Please note: Failure to include International Classification of Diseases, Tenth Revision (ICD-10) codes on electronic or paper claims will result in claim denial.

Claim submissions

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

Humana Healthy Horizons does not pay claims with incomplete, incorrect or unclear information. Providers have 30 calendar days from the date of service or discharge to submit a claim dispute.

Frequently used modifiers:

- Telehealth – GT Modifier
- AH/MO and 59 – if services performed on same date of service

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

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

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

- Patient (member) name
- Patient address
- Insured's ID number: Be sure to provide the complete Humana Healthy Horizons in South Carolina member ID for the patient
- Patient's birth date: Always include the member's date of birth so we can identify the correct member in case there is more than one member with the same name

Place of service:

- Use standard Centers for Medicare & Medicaid Services (CMS) location codes
- International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) diagnosis code(s)
- Health Insurance Portability and Accountability Act (HIPAA)-compliant Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code(s) and modifiers when modifiers are applicable
- Units, where applicable (anesthesia claims require number of minutes)

Date of service:

- Please include dates for each individual service rendered; date ranges are not accepted, even though some claim forms contain from/to formats. Please enter each date individually.
- Prior authorization number, when applicable: A number is needed to match the claim to the corresponding prior authorization information. This is only needed if the service provided requires prior authorization.

National Provider Identifier (NPI):

- Please refer to the Location of Provider NPI, Tax Identification Number (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 SCDHHS Master Provider List (MPL)
- Billing and rendering addresses that match the SCDHHS MPL

Signature of provider or supplier:

- The provider's complete name should be included. If we already have the provider's signature on file, indicate "signature on file," and enter the date the claim is signed in the date field.

Claim dispute process

Claim disputes are related to a presumed payment error that may occur for a variety of reasons. Claim dispute submissions must be received by Humana Healthy Horizons within 30 calendar days of the original claim adjudication date.

Electronic funds transfer/electronic remittance advice

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

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

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

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

EFT/ERA enrollment through Humana Healthy Horizons

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

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

To access this tool:

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

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

EFT payment transactions are reported with file format CCD+, which is the recommended industry standard for EFT payments. The CCD+ format is a National Automated Clearing House Association corporate payment format with a single, 80-character addendum record capability. The addendum record is used by the originator to provide additional information about the payment to the recipient. This format is also referenced in the ERA (835 data file). Contact your financial institution if you would like to receive this information.

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

The ERA replaces the paper version of the explanation of remittance (EOR). Humana Healthy Horizons delivers 5010 835 versions of all ERA remittance files that are HIPAA-compliant. Humana Healthy Horizons uses Availity Essentials as the central gateway for delivery of 835 transactions. You can access your ERA through your clearinghouse or through the secure provider tools available in the Availity Essentials portal, which opens a new window.

Submitting electronic transactions

Provider portal: Availity Essentials

Availity Essentials is a secure provider portal offering convenient self-service tools for working online with multiple payers, including Humana Healthy Horizons. Available features include:

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

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

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

Electronic data interchange clearinghouses

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

To submit claims electronically, providers must work with an electronic claim clearinghouse. Humana Healthy Horizons currently accepts South Carolina provider electronic claims through the clearinghouses listed below. Please contact the clearinghouse of your choice to begin electronic claim submission.

When filing an electronic claim, please use one of the following payer IDs:

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

The following is a list of some of the commonly used clearinghouses and phone numbers:

Availity Essentials	Availity.com	**800-282-4548**
TriZett	Trizetto.com	**800-556-2231**
McKesson	Mckesson.com	**800-765-6363**
Change Healthcare	Changehealthcare.com	**800-792-5256**
SSI Group	Thessigroup.com	**800-820-4774**

5010 transactions

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

The following transactions are covered under the 5010 requirements:

837P/837I claims encounters

835 electronic remittance advice

836 276/277 claims status inquiry

837 270/271 eligibility

838 278 prior authorization requests

839 834 enrollment

840 National Council for Prescription Drug Program (NCPDP)

841 provider type to taxonomy crosswalk

Procedure and diagnosis codes

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

- ICD-10-CM, available from the U.S. Government Printing Office by calling **202-512-1800** or faxing **202-512-2250**, and from other vendors
- Current Procedural Terminology (CPT), available at the American Medical Association's website
- Healthcare Common Procedure Coding System (HCPCS), available at CMS' HCPCS page
- National Drug Code (NDC), available at FDA.gov

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

Unlisted CPT/HCPCS codes

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

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

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

NPI, TIN and taxonomy

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

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

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

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

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

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

If your NPI and taxonomy codes change, please update your taxonomy information with Humana Healthy Horizons and the SCDHHS MPL. Providers can submit a demographic change request via Smart Form. You may also call Humana Healthy Horizons Provider Services at **866-432-0001** or contact your provider agreement representative for assistance. Please mail your changes to:

Humana provider correspondence
P.O. Box 14601
Lexington, KY 40512-4601

Location of provider NPI, TIN and member ID number

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

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

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

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

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN

- The billing provider taxonomy code in box 33b on 5010 (837I) Institutional Claims:
  The billing provider NPI should be in the following location:
  - 2010AA Loop – Billing provider name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = billing provider NPI

The billing provider TIN must be submitted as the secondary provider identifier using an REF segment, which is either the EIN for organizations or the Social Security number for individuals:

- Reference identification qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference identification – REF02 = Billing provider TIN or SSN

The billing taxonomy code goes in box 81. On all electronic claims, enter the Humana Healthy Horizons member ID in the following fields:

- 2010BA Loop = Subscriber name
- NM109 = Member ID number

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 UB92 form, for facilities

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

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

- CMS-1500 Form Instructions: Nucc.org
- UB-04 Form Instructions: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15_1450

Please mail all paper claim forms to Humana Healthy Horizons using the following address:

Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

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

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

Instructions for National Drug Code on paper claims

All of the following information is required for each applicable code required on a claim:

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

Tips for submitting paper claims

- Electronic claims are generally processed more quickly than paper claims.
- If you submit paper claims, we require the most current form version as designated by CMS and NUCC.
- Handwritten claims or super bills, including printed claims with handwritten information, are not 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 printing is aligned correctly so 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 SCDHHS MPL, including TIN, billing and rendering NPI, addresses and taxonomy codes.
- Coordination of benefits (COB) paper claims require a copy of the explanation of payment (EOP) from the primary carrier.

Out-of-network claims

Humana Healthy Horizons established guidelines for payments to out-of-network providers for preauthorized medically necessary services. These services are reimbursed, with prior authorization, at 100% of the South Carolina Medicaid fee schedule. If the service is not available from an in-network provider, Humana Healthy Horizons must make three documented attempts to contract with an out-of-network provider. Humana Healthy Horizons in South Carolina may reimburse that provider less than the Medicaid fee-for-service rate.

Claim processing guidelines

Timely filing

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

Coordination of benefits

- COB requires a copy of the appropriate remittance statement from the primary carrier payment, which should include:
  - Electronic claims – primary carrier's payment information
  - Paper claims – EOB from primary carrier
- Medicare COB claims - Appropriate remittance statement must be received within two years from the date of service or within six months from Medicare adjudication.
- Non-Medicare primary payer – Appropriate remittance statement must be received within one year from date of service or discharge.
- If a claim is denied for needed COB information, the provider must submit the appropriate remittance statement from the primary payer within the remainder of the initial claims timely filing period.

Other claim requirements

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

Claims compliance standards

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

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

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

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

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

Crossover claims

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

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

Claim status

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

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

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

Claim 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 identification of Humana entity.

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

Code editing

Humana Healthy Horizons uses code editing software to review the accuracy of claim coding, including the accuracy of diagnosis and procedure codes, to ensure claims are processed consistently, accurately and efficiently.

Our code editing review may identify coding conflicts or inconsistent information on a claim. For example, a claim may contain a conflict between the patient's age and the procedure code, such as the submission for an adult patient of a procedure code limited to services provided to an infant. Humana Healthy Horizons' code editing software resolves these conflicts or indicates a need for additional information from the provider. Humana Healthy Horizons' code editing review evaluates the appropriateness of the procedure code but not the medical necessity of the procedure.

Humana Healthy Horizons provides notification of upcoming code editing changes.

We publish new code editing rules and our rationales for these changes on the first Friday of each month at **Humana.com/provider/medical-resources/claims-payments/processing-edits**.

The following additional resources are provided to assist you with coding issues. More information on claims code editing rules can be found by visiting the following websites:

- **CMS' Medicaid National Correct Coding Initative**
- **Humana Healthy Horizons in South Carolina Claims Code Editing Rules**
- **Humana's code edit announcements**
- **Humana's claims coding guidelines**
- Code Edit Simulator on **Availity Essentials**

Coding and payment policies

Humana Healthy Horizons strives to implement commercial SCDHHS and federal standards regarding the acceptance, adjudication and payment of claims. These standards apply to the submitted code/code set(s) and related clinical standards for claims received electronically or on paper.

We apply HIPAA standards to all electronically received claims. Accordingly, we accept only HIPAA-compliant code sets (i.e., HCPCS, CPT, and ICD-10).

In addition, we follow CMS rules for Medicare and Medicaid coding standards.

Finally, generally accepted commercial health insurance rules regarding coding and reimbursement also are used when appropriate. Humana Healthy Horizons strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

To determine unit prices for a specific code or service, please visit www.scdhhs.gov/resource/fee-schedules.

Humana Healthy Horizons processes accurate and complete provider claims in accordance with our normal claims processing procedures, including, but not limited to, claims processing edits and claims payment policies and all applicable state and/or federal laws, rules and regulations. Please review Humana's Claims Resources for Providers to access a summary of changes to claims processing procedures; this summary of changes to claims processing procedures is not intended to be an exhaustive list.

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

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

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

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

Changes to these sources may lead Humana Healthy Horizons to modify current or adopt new claims processing procedures.

These claims processing procedures may result in an adjustment or denial of reimbursement, a request for the submission of relevant medical records prior to or after payment, or the recoupment or refund request of a previous reimbursement. You can access additional information by visiting Humana's **Claims Resources for Providers**.

An adjustment in reimbursement because of claims processing procedures is not an indication that the service provided is a non-covered service. Providers can dispute adjustments produced by these claims processing procedures by submitting a timely request to Humana Healthy Horizons. Additional information can be found at the **South Carolina Medicaid Provider Claims website**.

Humana Healthy Horizons seeks to apply fair and reasonable coding edits. We maintain a provider dispute function that reviews, on request, a claim denied based on the use of a certain code, the relationship between two or more codes, unit counts, or the use of modifiers. This review takes into consideration the previously mentioned SCDHHS, Medicaid, NCCI and national commercial standards when considering a dispute.

Authorization requests

Authorization is required after 24 visits. Authorization request forms can be found by visiting **South Carolina Medicaid Provider Prior Authorization** or **Preauthorization and Notification Lists for Healthcare Providers**.