Humana | Healthy Horizons™ in Ohio

Department: Utilization Management	**Policy and Procedure No:** MCD-OH-CLI=H1349	
Policy and Procedure Title: Home Health Services Medical Necessity		
Process Cycle: Annually	**Responsible Departments:** Clinical	
Approved By: Mark Rastetter MD	**Effective Date:** 2/1/2023	**Revised:**

POLICY AND PROCEDURE:

Policy:
Humana Healthy Horizons™ of Ohio will use established criteria guidelines to make medical necessity decisions on case-by-case basis, based on the information provided on the member's health status.

Procedure:
For Home Health services, Humana Healthy Horizons in Ohio uses OAC Rule 5160-12.

(A) "Home health services" includes home health nursing, home health aide services and skilled therapies.
(B) Home health services are reimbursable only if a qualifying treating physician, advance practice nurse or physician assistant certifying the need for home health services documents that he or she had a face-to-face encounter with the individual within ninety days prior to the start of care date, or within thirty days following the start of care date. To be a qualifying treating physician, the physician will be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery as authorized under Chapter 4731. of the Revised Code. Advanced practice registered nurses in accordance with rule 5160-4-04 of the Administrative Code or a physician assistant in accordance with rule 5160-4-03 of the Administrative Code have the authority to conduct the face-to-face encounter. The face-to-face encounter with the individual will occur independent of any provision of home health services to the individual. The face-to-face encounter may be completed using telehealth. The face-to-face encounter will be documented as follows:
(1) For home health services unrelated to an inpatient hospital stay, the face-to-face encounter will be documented by the qualifying treating physician, advance practice nurse or physician assistant using:
(a) The ODM 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2016) or
(b) The individual's plan of care if all of the data elements specified for home health services unrelated to an inpatient hospital stay on the ODM 07137 are included and the plan of care contains the signature, credentials and the date of the signature of the qualifying treating physician, advance practice nurse or physician assistant.
(2) For post hospital home health services, the face-to-face encounter will be documented by the clinician using the ODM 07137.
(3) For an individual dually eligible for medicare and medicaid, the face-to-face encounter will be documented by the treating clinician using the ODM 07137 if supporting documents are attached, or using the individual's plan of care pursuant to paragraph (B)(1)(b) of this rule when the face-to-face encounter date for medicare home health services falls within ninety days prior to the medicaid home health services start of care date, or within thirty days following the medicaid start of care date.

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(C) Home health services are covered only if provided on a part-time or intermittent basis, which means:

(1) No more than a combined total of eight hours per day of home health nursing, home health aide, and skilled therapies except as specified in paragraph (H) of this rule;

(2) No more than a combined total of fourteen hours per week of home health nursing and home health aide services except as specified in paragraphs (D) and (H) of this rule or as prior authorized by ODM or its designee; and

(3) Visits are not more than four hours. Nursing visits over four hours may qualify for coverage in accordance with rule 5160-12-02 of the Administrative Code.

(D) A combined total of twenty-eight hours per week of home health nursing and home health aide services is available to an individual for up to sixty consecutive days from the date of discharge from an inpatient hospital stay if all of the following are met as certified by the qualifying treating clinician using the ODM 07137:

(1) The individual is discharged from a covered inpatient hospital stay of three or more days, with the discharge date recorded on form ODM 07137. It is considered one inpatient hospital stay when an individual is transferred from one hospital to another hospital, either within the same building or to another location. The sixty days will begin once the individual is discharged to their place of residence or to a nursing facility from the last inpatient stay in an inpatient hospital or inpatient rehabilitation unit of a hospital.

(2) The individual has a comparable level of care as evidenced by either:

(a) Enrollment in a home and community based services (HCBS) waiver; or

(b) A medical condition that temporarily meets the criteria for an institutional level of care as described in rule 5160-3-08 of the Administrative Code or as defined in rule 5123:2-8-01 of the Administrative Code. In no instance does this requirement constitute the determination of a level of care for waiver eligibility status, or admission into a medicaid covered long term care institution.

(3) The individual requires home health nursing, or a combination of private duty nursing, home health nursing, or waiver nursing and/or skilled therapy services at least once per week and the services are medically necessary in accordance with rule 5160-1-01 of the Administrative Code.

(4) The individual has had a covered inpatient hospital stay of three or more days, with the discharge date recorded on form ODM 07137.

(E) Home health services may only be provided by a medicare certified home health agency (MCHHA) that meets the requirements in accordance with rule 5160-12-03 of the Administrative Code. In order for home health services to be covered, MCHHAs must:

(1) Provide home health services only if the clinician has documented a face-to-face encounter with the individual as specified in paragraph (B) of this rule.

(2) Provide home health services that are appropriate given the individual's diagnosis, prognosis, functional limitations and medical conditions as ordered by the individual's treating clinician for the treatment of the individual's condition, illness or injury.

(3) Provide home health services as specified in the individual's plan of care in accordance with rule 5160-12-03 of the Administrative Code. Home health services not specified in a plan of care are not reimbursable. Additionally the plan of care must provide the amount, scope, duration, and type of home health service as:

(a) Documented on the person-centered services plan as defined in rule 5160-45-01 of the Administrative Code that is prior approved by the Ohio department of medicaid (ODM) or designee when an individual is enrolled on an ODM administered HCBS waiver. Home health services that are not identified on the person-centered services plan are not reimbursable; or

(b) Documented on the services plan when an individual is enrolled on an Ohio department of aging (ODA) or Ohio department of developmental disabilities (DODD) administered HCBS waiver. Home health services that are not documented on the services plan are not reimbursable.

(4) Provide the home health services in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under medicaid for inpatient services that include room and board.

(5) Not provide home health nursing and home health aide services for the provision of habilitative care, or respite care, and not provide skilled therapies for the provision of maintenance care, habilitative care or respite care.

(a) "Maintenance care" is the care given to an individual for the prevention of deteriorating or worsening medical conditions or the management of stabilized chronic diseases or conditions. Services are considered maintenance care if the individual is no longer making significant improvement in his or her medical condition.

(b) "Habilitative care" is the care provided to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.

(c) "Respite care" is the care provided to an individual unable to care for himself or herself because of the absence or need for relief of those persons normally providing care.

(6) Bill for provided home health services in accordance with visit policy rule 5160-12-04 of the Administrative Code.

(7) Bill for provided home health services using the appropriate procedure code and applicable modifiers in accordance with rule 5160-12-05 of the Administrative Code.

(8) Bill after all documentation is completed for the services rendered during a visit in accordance with rule 5160-12-03 of the Administrative Code.

(F) Individuals who receive home health services will:

(1) Participate in a face-to-face encounter as specified in paragraph (B) of this rule for the purpose of certifying their medical need for home health services.

(2) Be under the supervision of a clinician who is providing care and treatment to the individual. The clinician will not be a clinician whose sole purpose is to sign and authorize plans of care or who does not have direct involvement in the care or treatment of the individual. A treating clinician may be a clinician who is substituting temporarily on behalf of a treating clinician.

(3) Participate in the development of a plan of care along with the treating clinician and the MCHHA.
(4) Access home health services in accordance with the program for the all-inclusive care of the elderly (PACE) when the individual participates in the PACE program.
(5) Access home health services in accordance with the individual's provider of hospice services when the individual has elected the hospice benefit.
(6) Access home health services in accordance with the individual's managed care plan when the individual is enrolled in a medicaid managed care plan.
(G) Covered home health services:
(1) "Home health nursing" is a nursing service that requires the skills of and is performed by a registered nurse, or a licensed practical nurse at the direction of a registered nurse. The nurse performing the home health service must possess a current, valid and unrestricted license with the Ohio board of nursing and must be employed or contracted by a MCHHA that has an active medicaid provider agreement. A service is not considered a nursing service merely because it is performed by a licensed nurse.
(a) Nursing tasks and activities that shall only be performed by an RN include, but are not limited to, the following:
(i) Intravenous (IV) insertion, removal or discontinuation;
(ii) IV medication administration;
(iii) Programming of a pump to deliver medications including, but not limited to, epidural, subcutaneous and IV (except routine doses of insulin through a programmed pump);
(iv) Insertion or initiation of infusion therapies;
(v) Central line dressing changes; and
(vi) Blood product administration.
(b) Home health nursing services performed by an RN and/or an LPN will be:
(i) Performed within the nurse's scope of practice as defined in Chapter 4723. of the Revised Code and rules adopted thereunder.
(ii) Provided and documented in accordance with the individual's plan of care in accordance with rule 5160-12-03 of the Administrative Code.
(iii) Provided during an in-person visit or using telehealth if clinically appropriate given the needs of the individual, the nature of the service, and the technology that is available.
(iv) Medically necessary in accordance with rule 5160-1-01 of the Administrative Code to care for the individual's illness or injury.
(c) Home health nursing services do not include:
(i) A visit when the sole purpose is for the supervision of the home health aide.
(ii) RN assessment services as defined in rule 5160-12-08 of the Administrative Code.
(iii) RN consultation services as defined in rule 5160-12-08 of the Administrative Code.
(2) "Home health aide services" are services that use the skills of and are performed by a home health aide employed or contracted by the MCHHA providing the service. Home health aide services:
(a) Are performed within the home health aide's scope of practice as defined in 42 C.F.R. 484.36 (October 1, 2016). The home health aide cannot be the parent, step-parent,

foster parent or legal guardian of an individual who is under eighteen years of age, or the individual's spouse.

(b) Are provided and documented in accordance with the individual's plan of care in accordance with rule 5160-12-03 of the Administrative Code.

(c) Are provided during an in-person visit or using telehealth if clinically appropriate given the needs of the individual, the nature of the service, and the technology that is available.

(d) Must be medically necessary in accordance with rule 5160-1-01 of the Administrative Code to care for the individual's illness or injury.

(e) Must be necessary to assist the nurse or therapist in the care of the individual's illness or injury, or help the individual maintain a certain level of health in order to remain in a home and community based setting.

(f) Include health related services including but not limited to:

(i) Bathing, dressing, grooming, hygiene, including shaving, skin care, foot care, ear care, hair, nail and oral care, that are needed to facilitate care or prevent deterioration of the individual's health, and including changing bed linens of an incontinent or immobile individual.

(ii) Feeding, assistance with elimination including administering enemas (unless the skills of a home health nurse are required), routine catheter care, routine colostomy care, assistance with ambulation, changing position in bed, and assistance with transfers.

(iii) Performing a selected nursing activity or task as delegated in accordance with Chapter 4723-13 of the Administrative Code, and performed as specified in the plan of care.

(iv) Assisting with activities such as routine maintenance exercises and passive range of motion as specified in the plan of care. These activities are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed. The plan of care is developed by either a licensed therapist or a licensed registered nurse within their scope of practice.

(v) Performing routine care of prosthetic and orthotic devices.

(g) May include incidental services, as long as they do not substantially extend the time of the visit.

(i) Incidental services are necessary household tasks that must be performed by someone to maintain a home and can include light chores, laundry, light house cleaning, preparation of meals, and taking out the trash.

(ii) The main purpose of a home health aide visit cannot be solely to provide these incidental services since they are not health related services.

(iii) Incidental services are to be performed only for the individual and not for other people in the individual's place of residence.

(3) "Skilled therapies" is defined as physical therapy, occupational therapy, and speech-language pathology services that require the skills of and are performed by skilled therapy providers to meet the individual's medical needs, promote recovery, and ensure medical safety for the purpose of rehabilitation.

(a) "Skilled therapy providers" are licensed physical therapists, occupational therapists, speech-language pathologists, licensed physical therapy assistants (LPTA) under the direction of a physical therapist, or certified occupational therapy assistants

(COTA) under the direction of a licensed occupational therapist who are contracted or employed by a MCHHA.

(b) "Rehabilitation" is the care of an individual with the intent of curing the individual's disease or improving the individual's condition by the treatment of the individual's illness or injury, or the restoration of a function affected by illness or injury.

(c) Skilled therapies:

(i) Must be provided to the individual within the therapist's or therapy assistant's scope of practice in accordance with sections 4755.44, 4755.07, and 4753.07 of the Revised Code.

(ii) Must be medically necessary in accordance with rule 5160-1-01 of the Administrative Code to care for the individual's illness or injury.

(iii) Must be provided and documented in the individual's plan of care in accordance with rule 5160-12-03 of the Administrative Code.

(iv) Must be reasonable in their amount, frequency, and duration. Treatment must be considered to be safe and effective treatment for the individual's condition according to the accepted standards of medical practice.

(v) Are provided with the expectation of the individual's rehabilitation potential according to the treating clinician's prognosis of illness or injury. The expectation of the individual's rehabilitation potential is that the condition of the individual will measurably improve within a reasonable period of time or the services are necessary to the establishment of a safe and effective maintenance program.

(vi) May include treatments, assessments and/or therapeutic exercises but cannot include activities that are for the general welfare of the individual, including motivational or general activities for the overall fitness of the individual.

(vii) Are provided during an in person visit or using telehealth if clinically appropriate given the needs of the individual, the nature of the service, and the technology that is available.

(H) An individual who meets the requirements in this paragraph may qualify for increased home health services. The MCHHA must assure and document that the individual meets all requirements in this paragraph prior to increasing services. The U5 modifier must be used when billing in accordance to rule 5160-12-05 of the Administrative Code. The use of the U5 modifier indicates that all conditions of this paragraph were met. The individual who meets the following requirements may receive an increase of home health services if he or she:

(1) Is under age twenty-one and requires services for treatment in accordance with Chapter 5160-14 of the Administrative Code for the healthchek program.

(2) Needs more than, as ordered by the treating clinician:

(a) Eight hours per day of any home health service, or a combined total of fourteen hours per week of home health aide and home health nursing as specified in paragraph (C) of this rule; or

(b) A combined total of twenty-eight hours per week of home health nursing and home health aide for sixty days as specified in paragraph (D) of this rule.

(3) Has a comparable level of care as evidenced by either:

(a) Enrollment in a HCBS waiver; or

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(b) A level of care evaluated initially and annually by ODM or its designee for an individual not enrolled in a HCBS waiver. The criteria for an institutional level of care, including a nursing facility-based level of care as defined in rule 5160-3-08 of the Administrative Code or an ICF-IID level of care as defined in rule 5123:2-8-01 of the Administrative Code. In no instance does this constitute the determination of a level of care for waiver eligibility purposes, or admission into a medicaid covered long term care institution; and

(4) Needs home health nursing or a combination of PDN, home health nursing, waiver nursing, and skilled therapy visits at least once per week that is medically necessary in accordance with rule 5160-1-01 of the Administrative Code as ordered by the treating clinician.

(I) Individuals subject to decisions regarding home health services made by ODM or its designee pursuant to this rule will be afforded notice and hearing rights to the extent afforded in division 5101:6 of the Administrative Code.

CPT® Code(s)	Description
99512	Home visit for hemodialysis
99511	Home visit for fecal impaction management and enema administration
99509	Home visit for assistance with activities of daily living and personal care
99507	Home visit for care and maintenance of catheter(s) (eg, urinary, drainage, and enteral)
99506	Home visit for intramuscular injections
99505	Home visit for stoma care and maintenance including colostomy and cystostomy
99504	Home visit for mechanical ventilation care
99503	Home visit for respiratory therapy care (eg, bronchodilator, oxygen therapy, respiratory assessment, apnea evaluation)
CPT® Category III Code(s)	**Description**
	NA
HCPCS Code(s)	**Description**
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes

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G0156	Services of home health/hospice aide in home health or hospice settings, each 15 minutes
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes
G0152	services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes

1) The Plan covers all benefits and services required in OAC chapter 5160 in the amount, duration, and scope for the same services furnished to members under the fee-for-service (FFS) Medicaid.
2) When applying coverage policies and medical necessity criteria, the Plan will consider individual member needs and an assessment of the local delivery system.
3) The Plan uses the following hierarchy of guidelines to review for medical necessity:
    a) Federal or state regulation, including medical criteria published in the Ohio Administrative Code, Chapter 5160.
    b) Nationally accepted evidence based clinical guidelines: MCG (formerly Milliman Care Guidelines), American Society of Addiction Medicine (ASAM) Level of Care Adolescent Guidelines and American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM Admission Guidelines)
    c) Humana Healthy Horizons in Ohio clinical policies
    d) In the case of no guidance from above, additional information that the clinical reviewer will consider, when available, includes:
        i. Clinical practice guidelines and reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered in determinations;
        ii. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment;
        iii. Medical association publications
        iv. Government-funded or independent entities that assess and report on clinical care
        v. decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
        vi. Published expert opinions;
        vii. Opinion of health professionals in the area of specialty involved;
        viii. Opinion of attending provider
    e) Dental: DentaQuest coverage guidelines and policies
    Dental Coverage - Humana Healthy Horizons in Ohio | Humana

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f) Vision: EyeMed coverage guidelines and policies
Vision Care - Humana Healthy Horizons - Ohio Medicaid | Humana

Only practitioners with the appropriate clinical expertise can make the decision to deny or reduce the amount, duration or scope of the services being requested.

Humana Healthy Horizons™ in Ohio requires prior authorization on all "Miscellaneous", "Unlisted", "Not Otherwise Specified" codes. Medical necessity documentation and rationale must be submitted with the prior authorization request. The medical director adheres to the above process to align criteria based on the information provided on the member's health status.

Members may request a copy of the medical necessity criteria by calling member services at 877-856-5702 (TTY:711), Monday-Friday, from 7 a.m. to 8 p.m.

Providers may submit a request for medical necessity request by calling 877-856-5707 (TTY:711), Monday – Friday, from 7 a.m. to 8 p.m. EST or emailing the request to OHMCDUM@humana.com.

RESOURCES:

- Ohio Administrative Code 5160-1-01 Medicaid medical necessity: definitions and principles. Retrieved December 22, 2022, from Ohio Administrative code: 5160-12 Rule 5160-12-01 - Ohio Administrative Code | Ohio Laws

CONTRACT LANGUAGE:

5. Coverage Requirements

a. Medical Necessity Criteria

i. Pursuant to OAC rule 5160-26-03, the MCO's coverage requirements and decisions must be based on the coverage and medical necessity criteria published in OAC Chapter 5160 and practice guidelines as specified in OAC rule 5160-26-05.1.

ii. The MCO must have objective, written criteria based on sound clinical evidence to make medical necessity and utilization decisions. The MCO must involve appropriate providers in the development, adoption, and review of medical necessity criteria. The MCO's written criteria must meet NCQA standards and must specify procedures for appropriately applying the criteria.

iii. The MCO must use ODM-developed medical necessity criteria where it exists. In the absence of ODM-developed medical necessity criteria, the MCO must use clinically-accepted, evidence-informed medical necessity criteria (e.g., InterQual®, MCG®, and ASAM) as approved by ODM.

iv. In the absence of ODM-developed medical necessity criteria or ODM-approved, clinically-accepted, evidence-informed medical necessity criteria, the MCO's adaptation or development of medical necessity criteria must be based upon evaluated, peer reviewed medical literature published in the United States.
   1. Peer reviewed medical literature must include investigations that have been reproduced by non-affiliated authoritative sources.
   2. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale that is based upon well-designed research and endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

v. When applying coverage policies and medical necessity criteria, the MCO must consider individual member needs and an assessment of the local delivery system.

DEFINITIONS:

Adverse Benefit Determination – As defined in OAC rule 5160-26-08.4, a Managed Care Organization's (MCO's):

a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
b. Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the MCO;
c. Denial, in whole or part, of payment for a service (a denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” is not an adverse benefit determination);
d. Failure to provide services in a timely manner as specified in OAC rule 5160-26-03.1;
e. Failure to act within the resolution timeframes specified in this rule; or

f. Denial of a member's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other member financial liabilities, if applicable.

American Society of Addiction Medicine (ASAM) – a professional medical society representing over 7,000 physicians, clinicians, and associated professionals in the field of addiction medicine. ASAM produces a comprehensive set of standards for placement, continued stay, transfer or discharge of patients with addition and co-occurring conditions used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.

MCG® – Formerly known as Milliman Care Guidelines, are nationally recognized guidelines used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.

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Medically Necessary or Medical Necessity – Has the same meaning as OAC rule 5160-1-01:

a. Medical necessity for individuals covered by early and periodic screening, diagnosis, and treatment (EPSDT) is defined as procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.
b. Medical necessity for individuals not covered by EPSDT is defined as procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability, and without which the person can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort.
c. Conditions of medical necessity are met if all the following apply:
    i. It meets generally accepted standards of medical practice;
    ii. It clinically appropriate in its type, frequency, extent, duration, and delivery setting;
    iii. It is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;
    iv. It is the lowest cost alternative that effectively addresses and treats the medical problem;
    v. Provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
    vi. It is not provided primarily for the economic benefit of the provider nor for the convenience of the provider or anyone else other than the recipient.
d. The fact that a physician, dentist, or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself, make the procedure, item, or service medically necessary and does not guarantee payment for it.
e. The definition and conditions of medical necessity articulated in this rule apply throughout the entire Medicaid program. More specific criteria regarding the conditions of medical necessity for particular categories of service may be set forth within ODM coverage policies or rules.

VERSION CONTROL

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Version Review Approval History				
Department:	**Purpose of Review**	**Reviewed and Approved By:**	**Date:**	**Additional Comments:**
Clinical	Policy Development		12/11/2022	

DISCLAIMER:

Humana follows all federal and state laws and regulations. Where more than one state is impacted by an issue, to allow for consistency, Humana will follow the most stringent requirement.

This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/procedure) is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/procedure) supersedes all other policies, requirements, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained by CMU to ensure no modifications have been made.

NON-COMPLIANCE:

Failing to comply with any part of Humana's policies, procedures, and guidelines may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to non-compliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Associate Support Center via Humana's secure intranet of Hi! (Workday & Apps/Associate Support Center).