2023-2024 Provider Manual

Humana Healthy Horizons® in Florida
is a Medicaid product of Humana Medical Plan, Inc.

Humana
Healthy Horizons®
in Florida

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Welcome

Thank you for your participation with Humana Healthy Horizons in Florida, where our goal is to provide quality services to Medicaid members.

This Humana Healthy Horizons in Florida Provider Handbook applies to providers who provide services to our members with the Humana Healthy Horizons in Florida Medicaid managed medical assistance program (MMA), long-term care (LTC) plan and comprehensive plan.

This Provider Handbook highlights the key points related to Humana's policy and procedures and is an extension to your provider agreement. It is intended to be a guideline to facilitate and inform you and your staff of the requirements of Florida MMA, LTC and comprehensive plans, what we need from you, and what you can expect from Humana Healthy Horizons in Florida. The guidelines outlined in this handbook are designed to assist you in providing caring, responsive service to our members.

Please note that the information under Section I – Humana medical plan (MMA) supplements the Humana Provider Manual for providers, hospitals and healthcare providers located at **Humana.com/Publications**.

You will be notified of updates to this handbook via bulletins and notices posted on our website at **Humana.com/Publications**. If you need further explanation on topics discussed in this handbook, please contact your local provider relations representative or contract specialist.

We look forward to a long and productive relationship with you and your staff.

Humana Healthy Horizons in Florida Medical Plan

Program description

Florida has offered Medicaid services since 1970. Medicaid provides healthcare coverage for income-eligible children, seniors, disabled adults and pregnant women.

It is funded by both the state and federal governments and includes both capitated health plans as well as fee-for-service coverage. The Agency for Healthcare Administration (AHCA) is responsible for administering the Medicaid program and will administer contracts, monitor health plan performance and provide oversight in all aspects of health plan operations. The state has sole authority for determining eligibility for Medicaid and whether Medicaid recipients are required to enroll in, may volunteer to enroll in, or may not enroll in a Medicaid health plan or are subject to annual enrollment.

The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services. This program is referred to as Statewide Medicaid Managed Care (SMMC).

In entering into a contract with AHCA to provide services to Medicaid beneficiaries, Humana has agreed to comply with the provisions of the Medicaid contract (the "contract") as well as with all applicable agency rules relating to the contract and the applicable provisions in the Florida Medicaid Handbook ("handbooks").

Humana's obligations under the contract include, but are not limited to:

- Maintaining a quality improvement program aimed at improving the quality of member outcomes
- Maintaining quality management and utilization management programs
- Furnishing AHCA with data as required under the contract and as may be required in additional ad hoc requests
- Collecting and submitting encounter data in the format and in the timeframes specified by AHCA

In signing this contract, Humana has been authorized to take whatever steps are necessary to ensure that providers are recognized by the state Medicaid program, including its Choice Counseling/Enrollment Broker contractor(s) as a participating provider of Humana.

In addition, Humana has the responsibility to ensure providers' submission of encounter data is accepted by the Florida Medicaid Management Information System (MMIS) and/or the state's encounter data warehouse.

The Florida Medicaid program is implementing a new system through which Medicaid members will receive services. This program is called the Statewide Medicaid Managed Care MMA program. The MMA program is comprised of several types of managed care plans:

- Health maintenance organizations
- Provider service networks
- Children's medical services network

Most Medicaid recipients must enroll in the MMA program. The following individuals are NOT required to enroll, although they may enroll if they choose to:

- Medicaid recipients who have other creditable healthcare coverage, excluding Medicare
- Persons eligible for refugee assistance
- Medicaid recipients who are residents of a developmental disability center
- Medicaid recipients enrolled in the developmental disabilities home- and community-based services
- Waiver or Medicaid recipients waiting for waiver services

To be a participating provider, you must be a Medicaid- registered provider who provides services in one of the following regions:

- Region 1: Escambia, Okaloosa, Santa Rosa and Walton counties
- Region 2: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla and Washington counties
- Region 3: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee and Union counties
- Region 4: Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia counties
- Region 5: Pasco and Pinellas counties
- Region 6: Hardee, Highlands, Hillsborough, Manatee and Polk counties
- Region 7: Brevard, Orange, Osceola and Seminole counties
- Region 8: Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota counties
- Region 9: Indian River, Martin, Okeechobee, Palm Beach and St. Lucie counties
- Region 10: Broward County
- Region 11: Miami-Dade and Monroe counties

Florida's MMA program is designed to implement a new statewide managed care delivery system that will improve outcomes, improve consumer satisfaction and reduce and control costs.

The Florida MMA program will focus on four key objectives to support successful implementation:

1. Preserving continuity of care
2. Requiring sufficient and accurate networks under contract and taking patients, allowing for an informed choice of plans for recipients and the ability to make an appointment
3. Paying providers fully and promptly to preclude provider cash flow or payroll issues, and to give providers ample opportunity to learn and understand the plan's prior authorization procedures
4. Coordinating with the Choice Counseling Call Center and website operated by the agency's contracted enrollment broker

Definitions

The following are definitions that are specific to this appendix:

Abuse (for program integrity functions) — Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for healthcare; or recipient practices that result in unnecessary cost to the Medicaid program.

Abuse, neglect and exploitation — In accordance with Chapter 415, F.S., and Chapter 39, F.S.: "Abuse" means any willful act or threatened act by a caregiver that causes, or is likely to cause, significant impairment to a member's physical, mental or emotional health. Abuse includes acts and omissions. "Neglect" of an adult means the failure or omission on the part of the caregiver to provide the care, supervision and services necessary to maintain the physical and behavioral health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision and medical services, that a prudent person would consider essential for the well-being of the vulnerable adult. The term "neglect" also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness that produces, or could reasonably be expected to result in, serious physical or psychological injury or a substantial risk of death. "Neglect" of a child occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter or medical treatment, or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, behavioral or emotional health to be significantly impaired or to be in danger of being significantly impaired. "Exploitation" of a vulnerable adult means a person who:

1. Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult's funds, assets or property for the benefit of someone other than the vulnerable adult
2. Knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, the vulnerable adult's funds, assets or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit or possession of the funds, assets or property for the benefit of someone other than the vulnerable adult

Action — The denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b). The reduction, suspension or termination of a previously authorized service. The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner, as defined by the state. The failure of the managed care plan to act within 90 days from the date the managed care plan receives a grievance, or 45 days from the date the

managed care plan receives an appeal. For a resident of a rural area with only one managed care entity, the denial of a member's request to exercise the right to obtain services outside the network.

Acute care services — Short-term medical treatment that may include, but is not limited to, community behavioral health, dental, hearing, home health, independent laboratory and X-ray, inpatient hospital, outpatient hospital/emergency medical, practitioner, prescribed drug, vision or hospice services.

Adjudicated claim — A claim for which a determination has been made to pay or deny the claim.

Advance directive — A written instruction, such as a living will or durable power of attorney for healthcare, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of healthcare when the individual is incapacitated.

Advanced registered nurse practitioner (ARNP) — A licensed advanced-practice registered nurse who works in collaboration with a practitioner according to Chapter 464, F.S., according to protocol, to provide diagnostic and clinical interventions. An ARNP must be authorized to provide these services by Chapter 464, F.S., and protocols filed with the Board of Medicine.

Adverse incident — An injury of a member occurring during delivery of managed care plan-covered services that:

1. Is associated in whole or in part with service provision rather than the condition for which such service provision occurred; and,
2. Is not consistent with or expected to be a consequence of service provision; or
3. Occurs as a result of service provision to which the patient has not given his informed consent; or
4. Occurs as the result of any other action or lack thereof on the part of the staff of the provider

After hours — The hours between 5 p.m. and 8 a.m. local time, Monday through Friday inclusive, and all day Saturday and Sunday. State holidays are included.

Agency — State of Florida, Agency for Healthcare Administration or its designee.

Aging and disability resource center (ADRC) — An agency designated by the Department of Elder Affairs (DOEA) to develop

and administer a plan for a comprehensive and coordinated system of services for older and disabled persons.

Ancillary provider — A provider of ancillary medical services who has contracted with a managed care plan to serve the managed care plan's members.

Appeal — A request for review of an action, pursuant to 42 CFR 438.400(b).

Area agency on aging — An agency designated by the DOEA to develop and administer a plan for a comprehensive and coordinated system of services for older persons.

Behavioral health services — Services specified in 409.973, F.S., in accordance with Attachment II., Section VI., Coverage and Authorization of Services, the approved federal waiver for the MMA managed care program, and the following Medicaid rules and services listed on the associated fee schedules including: Behavioral Health Assessment Services; Behavioral Health Community Support Services; Behavioral Health Intervention Services; Behavioral Health Medication Management Services; Behavioral Health Overlay Services; Behavioral Health Therapy Services; Child Health Services Targeted Case Management; Community Behavioral Health Services; Mental Health Targeted Case Management; Statewide Inpatient Psychiatric Program; Therapeutic Group Care Services and Specialized Therapeutic Services.

Behavioral healthcare provider — A licensed or certified behavioral health professional, such as a clinical psychologist under Chapter 490, F.S., clinical social worker, mental health professional under Chapter 491, F.S.; certified addictions professional; or registered nurse qualified due to training or competency in behavioral healthcare, who is responsible for the provision of behavioral healthcare to patients, or a physician licensed under Chapters 458 or 459, F.S., who is under contract to provide behavioral health services to members.

Beneficiary assistance program — A state external conflict resolution program authorized under s. 409.91211(3) (q), F.S., available to Medicaid participants, that provides an additional level of appeal if the managed care plan's process does not resolve the conflict.

Benefits — A schedule of healthcare services to be delivered to members covered by the Health Plan as set forth in Section V of the MMA contract and Section 2 of this Appendix.

Business days — Traditional workdays, which are Monday, Tuesday, Wednesday, Thursday and Friday. Federal holidays are excluded.

Calendar days — All seven days of the week. Unless otherwise specified, the term "days" in this attachment refers to calendar days.

Care coordination/case management — A process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet a member's health needs using communication and all available resources to promote quality outcomes. Proper care coordination/case management occurs across a continuum of care, addressing the ongoing individual needs of a member rather than being restricted to a single practice setting.

Case record — A record that includes information regarding the management of services for a member including the plan of care and documentation of care coordination/case management activities.

Cause — Special reasons that allow mandatory members to change their managed care plan choice outside their open enrollment period. May also be referred to as "for cause." (See 59G-8.600, F.A.C.)

Centers for Medicare & Medicaid Services (CMS) — The agency within the U.S. Department of Health and Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act.

Certification — The process of determining that a facility, equipment or an individual meets the requirements of federal or state law, or whether Medicaid payments are appropriate or shall be made in certain situations.

Children/adolescents — Members younger than 21.

Children's Medical Services (CMS) Network — A primary care case management program for children from

birth through age 21 with special healthcare needs, administered by the Department of Health for physical health services and the Department of Children and Families for behavioral health.

Children's medical services plan — A Medicaid specialty plan for children with chronic conditions operated by the Florida Department of Health's Children's Medical Services Network as specified in s. 409.974(4), F.S., through a single, statewide contract with the agency that is not subject to the SMMC procurement requirements, or regional plan limits, but must meet all other plan requirements for the MMA program.

Claim — (1) A bill for services, (2) a line item of service, or (3) all services for one (1) recipient within a bill, pursuant to 42 CFR 447.45, in a format prescribed by the agency through its Medicaid provider handbooks.

Clean claim — A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 CFR 447.45.

Commission for the transportation disadvantaged (CTD) — An independent commission housed administratively within the Florida Department of Transportation. The CTD's mission is to ensure the availability of efficient, cost-effective, and quality transportation services for transportation-disadvantaged persons.

Community care for the elderly lead agency — An entity designated by an Area Agency on Aging and given the authority and responsibility to coordinate services for functionally impaired elderly persons.

Community outreach — The provision of health or nutritional information or information for the benefit and education of, or assistance to, a community regarding health-related matters or public awareness that promotes healthy lifestyles. Community outreach also includes the provision of information about healthcare services, preventive techniques and other healthcare projects and the provision of information related to health, welfare and social services or social assistance programs offered by the state of Florida or local communities.

Community outreach materials — Materials regarding health or nutritional information or information for the benefit and education of, or assistance to, a community on health-related matters or public awareness that promotes healthy lifestyles. Such materials are meant specifically for the community at large and may also include information about healthcare services, preventive techniques and other healthcare projects and the provision of information related to health, welfare and social services or social assistance programs offered by the state of Florida or local communities. Community outreach materials are limited to brochures, fact sheets, billboards, posters and ad copy for radio, television, print or the Internet.

Community outreach representative — A person who provides health information, information that promotes healthy lifestyles, information that provides guidance about social assistance programs, and information that provides culturally and linguistically appropriate health or nutritional education. Such representatives must be appropriately trained, certified and/or licensed, including but not limited to, social workers, nutritionists, physical therapists and other healthcare professionals.

Complaint — Any oral or written expression of dissatisfaction by a member submitted to the health plan or to a state agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships, such as rudeness of a provider or health plan employee, failure to respect the member's rights, health plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the health plan's contract. A complaint is an informal component of the grievance system.

Continuous quality improvement — A management philosophy that mandates continually pursuing efforts to improve the quality of products and services produced by an organization.

Contract, medical assistance — As a result of receiving a regional award from the agency pursuant to s. 409.966(2), F.S., and/or s. 409.974, F.S., and successfully meeting all plan readiness requirements, the agreement between the managed care plan and the agency where the managed care plan will provide Medicaid-covered services to members, comprising the contract and any addenda, appendices, attachments or amendments thereto, and be paid by the agency as described in the terms of the agreement. Also referred to as the "contract."

County health departments (CHD) — CHDs are organizations administered by the Department of health for the purpose of

providing health services as defined in Chapter 154, F.S., which include the promotion of the public's health, the control and eradication of preventable diseases and the provision of primary healthcare for special populations.

Coverage and Limitations Handbook and/or Provider General Handbook (handbook) — A Florida Medicaid document that provides information to a Medicaid provider about member eligibility; claims submission and processing; provider participation; covered care, goods and services; limitations; procedure codes and fees; and other matters related to participation in the Medicaid program.

Covered services — Those services provided by the health plan in accordance with the health plan's Medicaid contract, and as outlined in Section V of the MMA contract and in Section 2 Covered Services of this appendix.

Crisis support — Services for persons initially perceived to need emergency behavioral health services, but upon assessment do not meet the criteria for such emergency care. These are acute care services available 24 hours a day, seven days a week (24/7) for intervention. Examples include mobile crisis, crisis/emergency screening, crisis hotline and emergency walk-in.

Department of children and families (DCF) — The state agency responsible for overseeing programs involving behavioral health, childcare, family safety, domestic violence, economic self-sufficiency, refugee services, homelessness and programs that identify and protect abused and neglected children and adults.

Department of elder affairs (DOEA) — The primary state agency responsible for administering human services programs to benefit Florida's elders and developing policy recommendations for long-term care in addition to overseeing the implementation of federally and state funded programs and services for the state's elderly population.

Department of health — The state agency responsible for public health, public primary care and personal health, disease control and licensing of health professionals.

Direct secure messaging (DSM) — Enables Managed Care Organizations and providers to securely send patient health information to many types of organizations.

Direct service behavioral healthcare provider — An individual qualified by training or experience to provide direct behavioral health services.

Disease management — A system of coordinated healthcare intervention and communication for populations with conditions in which patient self-care efforts are significant. Disease management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Disenrollment — The agency-approved discontinuance of a member's participation in a managed care plan.

Downward substitution — The use of less restrictive, lower-cost services than otherwise might have been provided, that are considered clinically acceptable and necessary to meet specified objectives outlined in a member's plan of treatment, provided as an alternative to higher cost services.

Dual eligible — A member who is eligible for both Medicaid (Title XIX) and Medicare (Title XVIII) programs.

Durable medical equipment (DME) — Medical equipment that can withstand repeated use, is customarily used to serve a medical purpose, is generally not useful in the absence of illness or injury and is appropriate for use in the member's home.

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) — As defined by 42 CFR 440.40(b) (2012) or its successive regulation, means: (1) screening and diagnostic services to determine physical or mental defects in recipients younger than 21; and (2) healthcare, treatment and other measures to correct or ameliorate any defects and chronic conditions discovered. Pursuant to s. 42 CFR 441.56 (2012) or its successive regulation, this is a program about which all eligible individuals and their families must be informed. EPSDT includes screening (periodic comprehensive child health assessments) consisting of regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status of infants, children and youth. As a minimum, these screenings must include, but are not limited to: (a) comprehensive health and developmental history, (b) comprehensive unclothed physical examination,

(c) appropriate vision testing, (d) appropriate hearing testing, (e) appropriate laboratory tests, (f) dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age.

Screening services must be provided in accordance with reasonable standards of medical and dental practice determined by the agency after consultation with recognized medical and dental organizations involved in child healthcare. Requirements for screenings are contained in the Medicaid well-child visits coverage and Limitations Handbook. Diagnosis and treatment include: (a) diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids; (b) dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and (c) appropriate immunizations. (If it is determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time.) (See definition of well-child visits program.)

Early intervention services (EIS) — A Medicaid program designed for children receiving services through the Department of Health's Early Steps program. Early Steps serves eligible infants and toddlers from birth to 36 months who have development delays or a condition likely to result in a developmental delay. EIS services are authorized in the child's Early Steps Individualized Family Support Plan and are delivered by Medicaid-enrolled EIS providers throughout the state.

Emergency behavioral health services — Those services required to meet the needs of an individual who is experiencing an acute crisis, resulting from a mental illness, which is a level of severity that would meet the requirements for an involuntary examination (see s. 394.463, F.S.), and in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

Emergency medical condition — A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the health of a patient, including a pregnant woman or fetus;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.
- With respect to a pregnant woman:
    - That there is inadequate time to affect safe transfer to another hospital prior to delivery;
    - That a transfer may pose a threat to the health and safety of the patient or fetus;
    - That there is evidence of the onset and persistence of uterine contractions or rupture of other membranes, Section 395.002.F.S.

Emergency services and care — Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If an emergency medical condition exists, emergency services and care include the care or treatment that is necessary to relieve or eliminate the emergency medical condition within the service capability of the facility.

Emergency transportation — The provision of emergency transportation services in accordance with s. 409.908 (13) (c)4., F.S.

Encounter data — A record of diagnostic or treatment procedures or other medical, allied or long-term care provided to the managed care plan's Medicaid members, excluding services paid by the agency on a fee-for-service basis.

Member — A Medicaid recipient currently enrolled in the health plan.

Members with special healthcare needs — Members who face physical, behavioral or environmental challenges daily that place at risk their health and ability to function fully in society. This includes individuals with mental retardation or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care; and all members in LTC Managed Care plans.

Enrollment — The process by which an eligible Medicaid recipient signs up to participate in a managed care plan.

Enrollment broker — The state's contracted or designated entity that performs functions related to outreach, education, enrollment and disenrollment of potential members into a managed care plan.

Enrollment specialists — Individuals, authorized through an agency-approved process, who provide one-on-one information to Medicaid recipients to help them choose the managed care plan that best meets the healthcare needs of them and their families.

Expanded benefit — A benefit offered to all members in specific population groups, covered by the managed care plan for which the managed care plan receives no direct payment from the agency.

Expedited appeal process — The process by which the appeal of an action is accelerated because the standard timeframe for resolution of the appeal could seriously jeopardize the member's life, health or ability to obtain, maintain or regain maximum function.

External quality review (EQR) — The analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness and access to the healthcare services that are furnished to Medicaid recipients by a health plan.

External quality review organization (EQRO) — An organization that meets the competence and independence requirements set forth in federal regulation 42 CFR 438.354, and performs external quality review (EQR), other related activities as set forth in federal regulations or both.

Facility-based — As the term relates to services, services the member receives from a residential facility in which the member lives. Under this contract, assisted living facility services, assistive care services, adult family care homes and nursing facility care are facility-based services.

Federally qualified health center (FQHC) — An entity that is receiving a grant under section 330 of the Public Health Service Act, as amended. (Also see s. 1905(l)(2)(B) of the Social Security Act.) FQHCs provide primary healthcare and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.

Fee schedule – A list of medical, dental or behavioral health services or products covered by the Florida Medicaid program, which provide the associated reimbursement rates for each covered service or product and are promulgated into rule.

Fee-for-service (FFS) — A method of making payment by which the agency sets prices for defined medical or allied care, goods or services.

Florida mental health act — Includes the Baker Act that covers admissions for persons who are considered to have an emergency mental health condition (a threat to themselves or others) as specified in ss. 394.451 through 394.47891, F.S.

Fraud — An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to that person or another person. The term includes any act that constitutes fraud under applicable federal or state law.

Full benefit dual eligible — A member who is eligible for full Medicaid benefits under Medicaid (Title XIX) and Medicare (Title XVIII) programs.

Functional status — The ability of an individual to perform self-care, self-maintenance and physical activities to carry on typical daily activities.

Grievance — An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships, such as rudeness of a provider or employee or failure to respect the member's rights.

Grievance process — The procedures for addressing members' grievances.

Grievance system — The system for reviewing and resolving member complaints, grievances and appeals. Components must include a complaint process, a grievance process, an appeal process, access to an applicable review outside the managed care

plan (Beneficiary Assistance Program) and access to a Medicaid Fair Hearing through the Department of Children and Families.

Health assessment — A complete health evaluation combining health history, physical assessment and the monitoring of physical and psychological growth and development.

Health fair — An event conducted in a setting that is open to the public or segment of the public (such as the elderly or schoolchildren) during which information about healthcare services, facilities, research, preventive techniques or other healthcare subjects is disseminated. At least one community organization or two health- related organizations that are not affiliated under common ownership must actively participate in the health fair.

Health information exchange (HIE) — The secure, electronic exchange of health information among authorized stakeholders in the healthcare community — such as care providers, patients and public health agencies — to drive timely, efficient, high-quality, preventive and patient-centered care.

Health Information Technology for Economic and Clinical Health (HITECH) Act — The Health Information Technology Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.

Healthcare professional — A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), a licensed clinical social worker, registered respiratory therapist and certified respiratory therapy technician.

Healthcare Effectiveness Data and Information Set (HEDIS®) — The data and information set developed and published by the National Committee for Quality Assurance. HEDIS includes technical specifications for the calculation of performance measures.

Healthcare-acquired condition (HCAC) — A condition, occurring in any inpatient hospital or inpatient psychiatric hospital setting, including crisis stabilization units (CSUs), identified as a hospital-acquired condition (HAC) by the Secretary of Health and Human Services under section 1886(d)(4)(D)(iv) of the Social Security Act for purposes of the Medicare program as specified in the Florida Medicaid State Plan. By federal law, Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE), as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients, are not reportable Provider-Preventable Conditions (PPCs)/Healthcare-Acquired Conditions (HCACs). HCACs also include never events.

Go365 for Humana Healthy Horizons program — A program offered by Managed Care plans that encourages and rewards behaviors designed to improve the member's overall health.

Hospital — A facility licensed in accordance with the provisions of Chapter 395, F.S., or the applicable laws of the state in which the service is furnished.

Licensed — A facility, equipment or an individual that has formally met state, county and local requirements, and has been granted a license by a local, state or federal government entity.

Licensed practitioner of the healing arts — A psychiatric nurse, registered nurse, advanced registered nurse practitioner, physician assistant, clinical social worker, mental health counselor, marriage and family therapist, or psychologist.

List of excluded individuals and entities (LEIE) — A database maintained by the Department of Health and Human Services, Office of the Inspector General. The LEIE provides information to the public, healthcare providers, patients and others relating to parties excluded from participation in Medicare, Medicaid and all other federal healthcare programs.

Managed behavioral health organization (MBHO) — A behavioral healthcare delivery system managing quality, utilization and cost of services. Additionally, an MBHO measures performance in the area of mental disorders.

Managed care plan — An eligible plan under contract with the agency to provide services in the MMA Statewide Medicaid Managed Care program.

MMA plan — A managed care plan that provides the services described in s.409.973, F.S., for the MMA Statewide Medicaid Managed Care (SMMC) program.

Mandatory assignment — The process the agency uses to assign members to a managed care plan. The agency automatically assigns those members required to be in a managed care plan who did not voluntarily choose one.

Mandatory member — The categories of eligible Medicaid recipients who must be enrolled in a managed care plan.

Mandatory potential member — A Medicaid recipient who is required to enroll in a managed care plan but has not yet made a choice.

Marketing — Any activity or communication conducted by or on behalf of any managed care plan with a Medicaid recipient who is not enrolled with the managed care plan or an individual potentially eligible for Medicaid that can be reasonably interpreted as intended to influence such individual to enroll in the particular managed care plan.

Medicaid — The medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., and regulations thereunder, as administered in the state of Florida by the agency under 409.901 et seq., F.S.

Medicaid fair hearing — An administrative hearing conducted by DCF to review an action taken by a managed care plan that limits, denies or stops a requested service.

Medicaid program integrity (MPI) — The unit of the agency responsible for preventing and identifying fraud and abuse in the Medicaid program.

Medicaid recipient — Any individual whom the DCF, or the Social Security Administration on behalf of the DCF, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods or services for which the agency may make payments under the Medicaid program, and who is enrolled in the Medicaid program.

Medicaid state plan — A written plan between a state and the federal government that outlines the state's Medicaid eligibility standards, provider requirements, payment methods and health benefit packages. A Medicaid State Plan is submitted by each state and approved by the Centers for Medicare & Medicaid Services (CMS).

Medical/case record — Documents corresponding to medical or allied care, goods or services furnished in any place of business. The records may be on paper, magnetic material, film or other media. To qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media.

Medically complex — An individual who is medically fragile who may have multiple comorbidities or be technologically dependent on medical apparatus or procedures to sustain life.

Medically necessary or medical necessity — Services that include medical or allied care, goods or services furnished or ordered to meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
- Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs;
- Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational;
- Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker or the provider.

Medically Necessary or Medical Necessity for those services furnished in a hospital on an inpatient basis cannot, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended or approved medical or allied goods or a service does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/ benefit.

Medicare — The medical assistance program authorized by Title XVIII of the Social Security Act.

Medicare advantage plan — A Medicare-approved health plan offered by a private company that covers both hospital and medical services, often includes prescription drug coverage, and may offer extra coverage such as vision, hearing, dental and/or wellness programs. Each plan can charge different out-of-pocket costs and have different rules for how to get services. Such plans can be organized as health maintenance organizations, preferred provider organizations, coordinated care plans and special needs plans.

Mental health targeted case manager — An individual who provides mental health targeted case management services directly to or on behalf of a member on an individual basis in accordance with 65E-15, F.A.C., and the Florida Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook.

National provider identifier (NPI) — An identification number assigned through the National Plan and Provider Enumerator System of the federal Department of Health and Human Services. NPIs can be obtained online at **https://nppes.cms.hhs.gov**.

Never event (NE) — As defined by the National Quality Forum (NQF), an error in medical care that is of concern to both the public and healthcare professionals and providers, clearly identifiable and measurable (and thus feasible to include in a reporting system) and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the healthcare organization. Currently, in Florida Medicaid, newer event healthcare settings are limited to inpatient hospitals and inpatient psychiatric hospitals, including CSUs.

Newborn — A live child born to a member of the health plan.

Non-covered service — A service that is not a covered service/benefit.

Nonparticipating provider — A person or entity eligible to provide Medicaid services that does not have a contractual agreement with the managed care plan to provide services. To receive payment for covered services, nonparticipating providers must be eligible for a Medicaid provider agreement and recognized in the Medicaid system (Florida MMIS) as either actively enrolled Medicaid providers or as managed care plan registered providers.

Normal business hours — The hours between 8 a.m. and 5 p.m. local time, Monday — Friday inclusive. Federal holidays are excluded.

Nursing facility — An institutional care facility that furnishes medical or allied inpatient care and services to individuals needing such services.

Other provider-preventable condition (OPPC) — A condition occurring in any healthcare setting that:

- Is identified in the Florida Medicaid State Plan;
- Is reasonably preventable through the application of procedures supported by evidence-based guidelines;
- Has a negative consequence for the beneficiary;
- Is auditable; and
- Includes, at a minimum, the following:
    - Wrong surgical or other invasive procedure performed on a patient;
    - Surgical or other invasive procedure performed on the wrong body part; and
    - Surgical or other invasive procedure performed on the wrong patient.

Outpatient — A patient of an organized medical facility, or distinct part of that facility, who is expected by the facility to receive, and who does receive, professional services for less than a 24-hour period, regardless of the hours of admission, whether a bed is used and/or whether or not the patient remains in the facility past midnight.

Overpayment — Overpayment defined in accordance with s. 409.913, F.S., includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

Participating provider — A healthcare practitioner or entity authorized to do business in Florida and contracted with the managed care plan to provide services to the managed care plan's members.

Participating specialist — A physician, licensed to practice medicine in the state of Florida, who contracts with the health plan to provide specialized medical services to the health plan's members.

Patient responsibility — The cost of Medicaid long-term care services not paid for by the Medicaid program, for which the member is responsible. Patient responsibility is the amount members must contribute toward the cost of their care. This is determined by the DCF's Economic Self Sufficiency and is based on income and type of placement.

Peer review — An evaluation of the professional practices of a provider by the provider's peers. The evaluator assesses the necessity, appropriateness and quality of care furnished by comparing the care to that customarily furnished by the provider's peers and to recognized healthcare standards.

Person (entity) — Any natural person, corporation, partnership, association, clinic, group or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of healthcare.

Physician assistant (PA) — A person who is a graduate of an approved program or its equivalent or meets standards approved by the Board of Medicine or the Board of Osteopathic Medicine, and is certified to perform medical services delegated by the supervising physician in accordance with Chapter 458, F.S.

Physicians' Current Procedural Terminology (CPT®) — A systematic listing and coding of procedures and services published annually by the American Medical Association.

Portable X-ray Equipment — X-ray equipment transported to a setting other than a hospital, clinic or office of a physician or other licensed practitioner of the healing arts.

Post-stabilization Care Services — Covered services related to an emergency medical condition that are provided after a member is stabilized to maintain, improve or resolve the member's condition pursuant to 42 CFR 422.113.

Potential Member — Pursuant to 42 CFR 438.10(a), an eligible Medicaid recipient who is subject to mandatory assignment or who may voluntarily elect to enroll in a given managed care plan but is not yet a member of a specific managed care plan.

Pre-enrollment — The provision of marketing materials to a Medicaid recipient.

Preferred Drug List — A listing of prescription products selected by a pharmaceutical and therapeutics committee as cost-effective choices for clinician consideration when prescribing for Medicaid recipients.

Prescribed Pediatric Extended Care (PPEC) — A nonresidential healthcare center for children who are medically complex or technologically dependent and require continuous therapeutic intervention or skilled nursing services.

Primary Care — Comprehensive, coordinated and readily accessible medical care including health promotion and maintenance; treatment of illness and injury; early detection of disease; and referral to specialists when appropriate.

Primary Care Case Management — The provision or arrangement of members' primary care and the referral of members for other necessary medical services on a 24- hour basis.

Primary care provider (PCP) — A health plan staff or contracted physician practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioner, physician assistant or other specialty approved by the agency, who furnishes primary care and patient management services to a member, and refers the member to a specialist when necessary.

Primary dental provider (PDP) — A managed care plan staff or subcontracted dentist practicing as a general dentist or pediatric dentist who furnishes primary dental care and patient management services to a member.

Prior authorization — The act of authorizing specific services before they are rendered.

Protected health information (PHI) — For purposes of this attachment, protected health information shall have the same meaning and effect as defined in 45 CFR 160 and 164, limited to the information created, received, maintained or transmitted by the managed care plan from, or on behalf of, the agency.

Protocols — Written guidelines or documentation outlining steps to be followed for handling a particular situation, resolving a problem or implementing a plan of medical, nursing, psychosocial, developmental and educational services.

Provider — A person or entity that has a Medicaid provider agreement in effect with the agency, and a contractual agreement with the health plan.

Provider contract — An agreement between the health plan and a healthcare provider as described above.

Provider-preventable condition (PPC) — A condition that meets the definition of a healthcare-acquired condition or other provider-preventable condition as defined in 42 CFR 447.26(b). PPCs include healthcare-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs) in inpatient hospital and inpatient psychiatric hospital settings, including crisis stabilization units (CSUs).

Public event — An event that is organized or sponsored by an organization for the benefit and education of or assistance to a community regarding health-related matters or public awareness. A managed care plan may sponsor a public event if the event includes active participation of at least one community organization or two health-related organizations not affiliated with the managed care plan.

Quality — The degree to which a health plan increases the likelihood of desired health outcomes of its members through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality enhancements — Certain health-related, community-based services that the managed care plan must offer and coordinate access to its members. Managed Care plans are not reimbursed by the agency/Medicaid for these types of services.

Quality improvement (QI) — The process of monitoring and ensuring that the delivery of healthcare services are available, accessible, timely, medically necessary and provided in sufficient quantity, of acceptable quality, within established standards of excellence and appropriate for meeting the needs of the members.

Region — The designated geographical area within which the managed care plan is authorized by the contract to furnish covered services to members. The managed care plan must serve all counties in the region(s) for which it is contracted. The 67 Florida counties are divided into 11 regions pursuant to s. 409.966(2), F.S. May also be referred to as "service area."

Registered nurse (RN) — An individual who is licensed to practice professional nursing in accordance with Chapter 464, F.S.

Registered provider — A provider registered with Florida Medicaid Management Information System (FMMIS) via the managed care plan. Such providers cannot bill Medicaid through fee-for-service claims submissions. Registered providers are assigned a Medicaid provider identification number for encounter data purposes only.

Remediation — The act or process of correcting a fault or deficiency.

Risk adjustment (also Risk-adjusted) — In a managed healthcare setting, risk adjustment of capitation payments is the process used to distribute capitation payments across Managed Care plans based on the expected health risk of the members enrolled in each managed care plan.

Risk assessment — The process of collecting information from a person about hereditary, lifestyle and environmental factors to determine specific diseases or conditions for which the person is at risk.

Rural — An area with a population density of less than 100 individuals per square mile, or an area defined by the most recent U.S. Census as rural; i.e., lacking a metropolitan statistical area (MSA).

Rural health clinic (RHC) — A clinic located in an area that has a healthcare provider shortage. An RHC provides primary healthcare and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services. An RHC employs, contracts or obtains volunteer services from licensed healthcare practitioners to provide services.

Sanctions — In relation to Section VIII.F: Any monetary or non-monetary penalty imposed upon a provider, entity or person (e.g., a provider entity or person being suspended from the Medicaid program). A monetary sanction under Rule 59G-9.070, F.A.C. may be referred to as a "fine." A sanction may also be referred to as a disincentive.

Screen or screening — A brief process, using standardized health screening instruments, used to make judgments about a

member's health risks to determine if a referral for further assessment and evaluation is necessary.

Serious injury — Any significant impairment of the physical condition of the patient as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Service authorization — The managed care plan's approval for services to be rendered. The process of authorization must at least include a member's or a provider's request for the provision of a service.

Service delivery systems — Mechanisms that enable provision of certain healthcare benefits and related services for Medicaid recipients as provided in s. 409.973, F.S., which include, but are not limited to, the Medicaid fee-for-service program and the Medicaid MMA program.

Sick care — Non-urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease).

Special Supplemental Nutrition Program for Women, Infants and Children (WIC) — Program administered by the Department of Health that provides nutritional counseling, nutritional education, breast-feeding promotion and nutritious foods to pregnant, postpartum and breast-feeding women, infants and children up to the age of 5 who are determined to be at nutritional risk and who have a low-to-moderate income. An individual who is eligible for Medicaid is automatically income-eligible for WIC benefits. Additionally, WIC income eligibility is automatically provided to a member's family that includes a pregnant woman or infant certified eligible to receive Medicaid.

Spoken script – Standardized text used by managed care plan staff in verbal interactions with members and/or potential members designed to provide information and/ or to respond to questions and requests. Spoken scripts also include interactive voice recognition (IVR) and on-hold messages. Marketing scripts are intended to influence such individuals to enroll in the particular managed care plan.

State — State of Florida.

Statewide inpatient psychiatric program (SIPP) — A 24- hour inpatient residential treatment program funded by Medicaid that provides mental health services to children younger than 21 years of age.

Subcontract — An agreement entered into by the health plan for provision of some of its functions, services or responsibilities for providing services under this contract.

Subcontractor — Any person or entity with which the health plan has contracted or delegated some of its functions, services or responsibilities for providing services under this contract.

Temporary assistance to needy families (TANF) — Public financial assistance provided to low-income families through DCF.

Temporary loss period — Period in which a member loses eligibility and regains it, allowing the recipient to be re- enrolled in the managed care plan in which the recipient was enrolled prior to the eligibility loss.

Transportation — An appropriate means of conveyance furnished to a member to obtain Medicaid authorized/ covered services.

Unborn activation — The process by which an unborn child, who has been assigned a Medicaid ID number, is made Medicaid-eligible upon birth.

Urban — An area with a population density of greater than 100 individuals per square mile or an area defined by the most recent U.S. Census as urban; i.e., as having a metropolitan statistical area (MSA).

Urgent behavioral healthcare — Those situations that require attention and assessment within 23 hours even though the member is not an immediate danger to self or others and is able to cooperate in treatment.

Urgent care — Services for conditions, which, though not life-threatening, could result in serious injury or disability unless

medical attention is received (e.g., high fever, animal bites, fractures, severe pain, etc.) or could substantially restrict a member's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

Validation — The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Voluntary member — A Medicaid recipient who is not mandated to enroll in a managed care plan but chooses to do so.

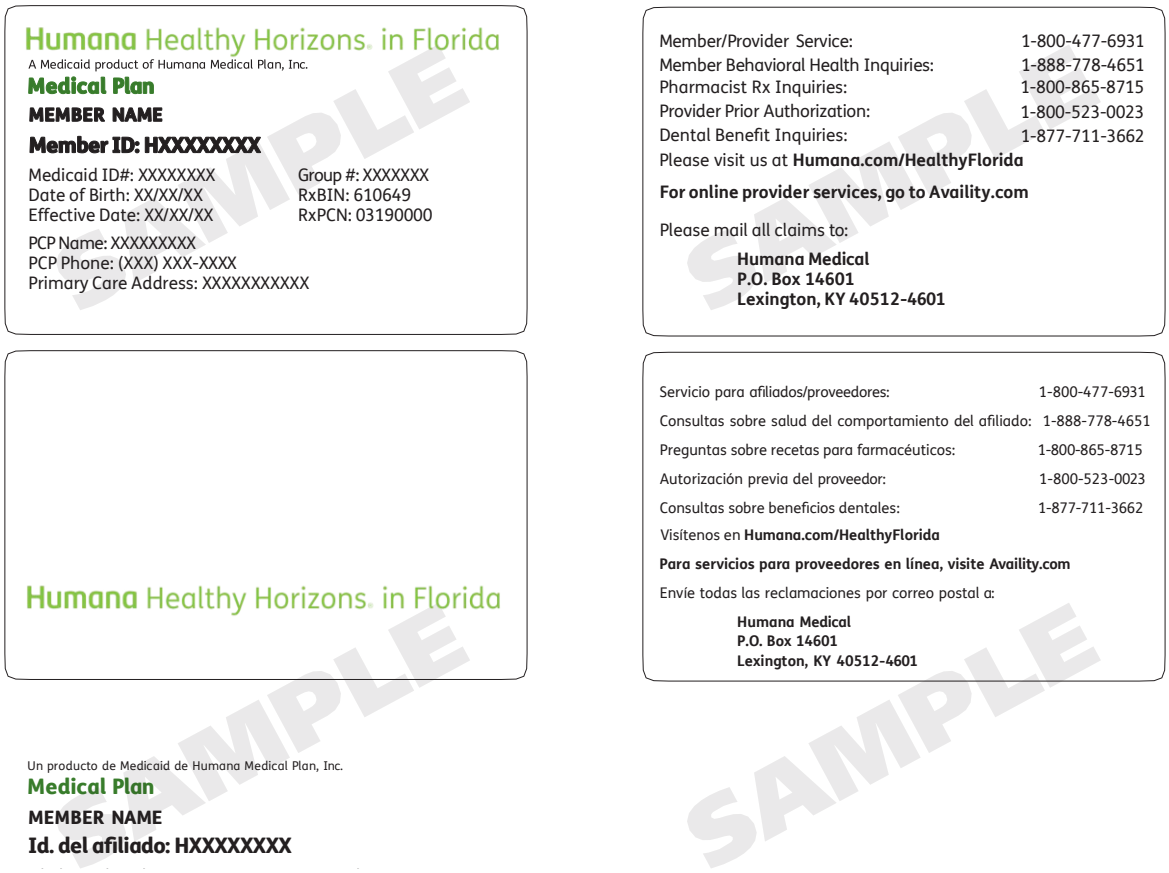
Voluntary potential member — A Medicaid recipient who is not mandated to enroll in a managed care plan, has expressed a desire to do so, but is not yet enrolled in a managed care plan.

Well-care visit — A routine medical visit for one of the following: well child visit, family planning, routine follow-up for a previously treated condition or illness, adult physicals or any other routine visit for other than the treatment of an illness.

Well-child visits — Comprehensive and preventive health examinations provided on a periodic basis that are aimed at identifying and correcting medical conditions in children/adolescents. Policies and procedures are described in the Well- Child Visits Coverage and Limitations Handbook.

Member identification (ID) card

Each member will receive an ID card from Humana Healthy Horizons in Florida. If the member loses his/her card, the member may call Member Services at **800-477-6931 (TTY: 711)** to obtain a new one.



Covered services

General services

Humana Healthy Horizons in Florida, through its contracted providers, is required to arrange for the following medically necessary services for each patient:

- ARNP services

- Ambulatory surgical centers
- Assistive care services
- Behavioral health services —inpatient and outpatient
- Birth center services
- Well-child visits
- Child health services targeted case management
- Chiropractic services
- Clinical services
- Community mental health services
- County health department services
- Dental services
- DME and medical supplies
- Dialysis services
- EIS
- Emergency behavioral health services
- Emergency services
- Family planning services and supplies
- FQHC services
- Healthy Start services for pregnant members
- Hearing services
- Home health services and nursing care
- Hospital services — inpatient/outpatient
- Imaging services
- Immunizations
- Laboratory services
- Licensed midwife services
- Massage therapy for member with AIDS
- Medical foster care
- Medication management services
- Nursing facility services
- Optometric and vision services
- Personal care for members with AIDS
- Physician assistant services
- Podiatry services
- Primary care case management services
- Primary care services
- Prescribed drug services
- Private duty nursing
- Prosthetics and orthotics
- Respiratory services
- RHC services
- Specialty provider services
- Targeted case management
- Therapy services (Occupational, physical, respiratory and speech)
- Transplant services
- Transportation services
- X-ray services, including portable X-rays

In providing covered services to Medicaid members, the provider is required to adhere to applicable provisions in the Florida Medicaid Coverage and Limitations Handbook, as well all state and federal laws pertaining to the provision of such services.

Out-of-network care for services not available

Humana Healthy Horizons in Florida will arrange for out-of-network care if it is unable to provide members with necessary covered services or a second opinion, if a network healthcare provider is not available. Humana Healthy Horizons in Florida will coordinate payment with the out-of-network provider to confirm that any cost to the member is not greater than it would be if the service were provided in-network.

Expanded services

Expanded services are those services offered by Humana Healthy Horizons in Florida and approved in writing by the agency. Such expanded benefits are those services or benefits not otherwise covered or that exceed limits outlined in the Medicaid State Plan and the Florida Medicaid Coverage and Limitations handbooks and the Florida Medicaid Fee Schedules. These services are in excess of the amount, duration and scope of those services listed above. In instances where an expanded benefit is also a Medicaid covered service, the managed care plan shall administer the benefit in accordance with any applicable service standards pursuant to this contract, the Florida Medicaid State Plan and any Medicaid Coverage and Limitations handbooks. Humana Healthy Horizons in Florida members have specific enhanced benefits. Please see the member handbook for benefit descriptions and details.

If copayments are waived as an expanded benefit, the provider must not charge members copayments for covered services; and if copayments are not waived as an expanded benefit, that the amount paid to providers shall be the contracted amount or for FFS Managed Care plans, the Medicaid fee schedule amount, less any applicable copayments.

Emergency service responsibilities

Participating providers are required to ensure adequate accessibility for healthcare 24 hours per day, seven days per week. Members should call their PCP first if they have an emergency, but go to the closest emergency room or any other emergency setting if they have an emergency such as any of the following:

- Heavy blood loss
- Heart attack
- Severe cuts requiring stitches
- Loss of consciousness
- Poisoning
- Severe chest pains
- Loss of breath
- Broken bones

Members are instructed to call their PCP as soon as possible when they are in a hospital or have received emergency care. When a member arrives at a hospital seeking emergency services and care, the determination that an emergency medical condition exists shall be made, for the purposes of treatment, by a provider of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician. See ss. 409.9128, 409.901, F.S. and 641.513, F.S.

If the emergency room doctor treating the member tells the member that the visit is not an emergency, the member will be given the choice to stay and receive medical treatment or follow up with his/her PCP. If the member decides to stay and receive treatment, then the services rendered will not be a covered benefit.

If the member's PCP responds to the hospital's notification, and the hospital physician and the PCP discuss the appropriate care and treatment of the member, the managed care plan may have a member of the hospital staff with whom it has a participating provider contract participate in the treatment of the member within the scope of the providers hospital staff privileges.

If the member is treated for an emergency and the treating doctor recommends treatment after the member is stabilized, the member is instructed to call his/her Humana Healthy Horizons in Florida PCP.

Members who are away from home and have an emergency are instructed to go to the nearest emergency room or any emergency setting of their choice. In such situations, members should call their PCP as soon as possible.

Emergency behavioral health services

For mental health services, members should call the mental healthcare provider in their area. The provider can assist with addressing their behavioral health needs. Members may call Humana Healthy Horizons in Florida's behavioral health toll-free number at **844-265-7590**.

Treatment for psychiatric and emotional disorders includes the following services:

- Counseling
- Evaluation and testing services
- Therapy and treatment services
- Rehabilitation services
- Children's behavioral healthcare services
- Day treatment services

For emergency mental healthcare within or outside the service area, please instruct members to go to the closest hospital emergency room or any other recommended emergency setting. They should contact you first if they are not sure the problem is an emergency.

Emergency mental health conditions include:

- Danger to themselves or others
- Unable to carry out actions of daily life due to functional harm
- Serious harm to the body that may cause death

In addition, the plan and the mental health provider shall ensure:

1. The member has a follow-up appointment within seven days after discharge; and
2. All required prescriptions are authorized at the time of discharge
3. Coordination of care. Discharge planning begins upon admission and is designed for early identification of medical and/or psychosocial issues that will need post-hospital intervention. Discharge plans from behavioral health inpatient admissions will be monitored to ensure that they incorporate the member's needs for continuity in existing behavioral health therapeutic relationships. Behavioral health care Providers should assign a mental health targeted case manager to oversee the care given to the Member to ensure a smooth transition to a lower level of care. The concurrent review clinician works with the attending physician, hospital discharge planner, family members, guardians, ancillary providers and/or community resources to coordinate care and post- discharge services to facilitate a smooth transfer of the member to the appropriate level of care. An inpatient review nurse may refer an inpatient member with identified complex discharge needs to transitional care management for in-facility outreach.

Well-child visits

Prescribing psychotropic medication to a child

Florida statute requires that providers have express and informed consent from a child's parent or legal guardian for the prescription of a psychotropic (psychotherapeutic) medication to a child in the Medicaid program. The provider needs to document the consent in the child's medical record and provide the pharmacy with a signed attestation of this documentation with the prescription. A "child" means a person from birth until the person's 13th birthday.

The attestation must be completed and presented to the pharmacy with every new prescription. The word "new" refers to every time a new prescription number is assigned, and includes all new prescriptions, including same drug/ same dose prescriptions for continuing therapy. It does not replace prior authorization requirements for medications not included on the preferred drug list (PDL) or prior authorized antipsychotics for the children and adolescents birth through 17 years of age.

Prescriptions may be phoned in or emailed for these medications when the child is younger than 13. The pharmacist should obtain a completed consent form from the prescriber via fax, mail or from the guardian prior to dispensing.

Psychotropic medications include antipsychotics, antidepressants, antianxiety medications and mood stabilizers. Anticonvulsants and attention-deficit hyperactivity disorder (ADHD) medications (stimulants and non-stimulants) are not included at this time.

For additional information, including a list of generic names of medications subject to the informed consent and a link to a

variety of consent forms allowed, please visit **ahca.myflorida.com/medicaid/Prescribed_Drug/banners.shtml**.

Medicaid well-child visit (child health checkup)

The Medicaid well-child visit (child health checkup) is a regularly scheduled comprehensive, preventive health screening service for children from birth through age 20. Well-child visits are performed according to a periodic schedule to

help children have a routine health screening to identify and correct medical conditions before the conditions become more serious and potentially disabling. The well-child visit is part Florida's EPSDT program.

What are the components of the well-child visits?

A well-child visit is composed of the following:

- Comprehensive health and developmental history, including assessment of past medical history, developmental history and behavioral health status
- Nutritional assessment
- Developmental assessment
- Comprehensive unclothed physical examination
- Dental screening, including dental referral, when required
- Vision screening, including objective testing, when required
- Hearing screening, including objective testing, when required
- Laboratory test, including blood lead testing, when required
- Appropriate immunizations
- Health education, anticipatory guidance
- Diagnosis and treatment
- Referral and follow up, as appropriate

Well-child visits information and screening codes

The procedure codes for well-child visits service are the Current Procedural Terminology (CPT) Preventive Medicine Services Codes. In some cases, one or two modifiers are required to uniquely identify the service provided. Both the procedure code and modifiers listed must be completed on the claim to receive proper reimbursement. No modifiers other than the ones listed in this chapter are allowed with billing these services.

Humana Healthy Horizons in Florida must ensure that its managed Medicaid members receive these checkups, so confirming that they are billed correctly is critical. Please note: Providers can bill a sick visit in addition to the well-child visit and receive reimbursement for both.

Well-child visit age or description	Well-child visit ICD-10 codes	New patient CPT codes	Established patient CPT codes
Neonatal exam	NA	99460, 99461, 99463	NA
Two to four days for newborns discharged less than 48 hours after delivery	NA		
By 1 month	NA	99381	99391
2 months	NA		
4 months	NA		
6 months	NA		
9 months	NA		
12 months	NA		

15 months	NA	99382	99392
18 months	NA		
2 years to younger than 5 years	NA		
5 years to younger than 12 years	NA	99383	99393
12 years to younger than 18 years	NA	99384	99394
18 years to younger than 21 years	NA	99385 EP	99395 EP
Encounter for health supervision and care	Z76.2	99202 – 99205	99213 – 99215
Encounter for routine child health exam	Z00.121		
Encounter for routine child health exam	Z00.129		
Health exam for newborn younger than 8	Z00.110		
Health exam for newborn younger than 8 to	Z00.111		
Encounter for general adult medical exam	Z00.00-01		
Encounter for exam for admission to	Z02.0		
Encounter for pre-employment exam	Z02.1		
Encounter for exam for admission to	Z02.2		
Encounter for exam for recruitment to	Z02.3		
Encounter for exam for driving license	Z02.4		
Encounter for exam for participation in	Z02.5		
Encounter for insurance purposes	Z02.6		
Encounter for paternity testing	Z02.81		
Encounter for adoption services	Z02.82		
Encounter for blood-alcohol and blood-drug	Z02.83		
Encounter for other administration exam	Z02.89		
Encounter for other general exam	Z00.8		
Encounter for exam for normal comparison	Z00.6		
Encounter for exam of potential donor of	Z00.5		

Encounter for exam for period of delayed growth in childhood without abnormal findings	Z00.70		
Encounter for exam for period of delayed	Z00.71		

Notes: The child may enter the periodic schedule at any time. For example, if a child has an initial screening at age 4, then the next periodic screening is performed at age 5. Get more information.

Child blood lead screenings

Federal regulations also require that children receive a blood screening for lead test at 12 months and 24 months. Children aged 36 to 72 months who have not previously been screened also should be screened for lead poisoning. Humana Healthy Horizons in Florida recommends that healthcare providers use a verbal lead- screening questionnaire to assess the risk of elevated levels in children 6 months to 6 years old. Taking Centers for Disease Control and Prevention (CDC) guidelines and recommendations into account, children whose blood lead levels are found to be 5 mcg/dL or greater (by venous sampling) should be treated and managed according to the providers discretion. Follow-up visits should include identification of possible sources of lead, appropriate treatment and periodic repeat testing.

Provider responsibilities

It is agreed that the Humana Healthy Horizons in Florida provider will:

- Provide a health screening evaluation consisting of comprehensive health and developmental history (including past medical history assessment)
- Provide developmental history behavioral health status
- Conduct a comprehensive unclothed physical examination
- Conduct developmental assessment
- Conduct nutritional assessment
- Immunize as required by the appropriate CDC Recommended Childhood Immunization Schedule
- Offer health education (including anticipatory guidance)
- Conduct a dental screening (including a direct referral to a dentist for members beginning at 3 years of age or earlier as indicated)
- Conduct a vision screening, including objective testing as required
- Conduct a hearing screening, including objective testing as required
- Provide diagnosis and treatment
- Provide referral to a specialist as needed and follow-up as appropriate
- For children/adolescents who the PCP identifies through blood lead screenings as having abnormal levels of lead, the PCP should provide case management follow-up services as required in Chapter 2 of the Well-Child Visits Coverage and Limitations Handbook. Screening for lead poisoning is a required component of health screening. Humana Healthy Horizons in Florida requires all providers to screen all enrolled children for lead poisoning at 12 and 24 months. In addition, children between the ages of 12 months and 72 months must receive a blood screening lead test if there is no record of a previous testing. The PCP should provide additional diagnostic and treatment services determined to be medically necessary to a child diagnosed with an elevated blood lead level. The PCP should recommend, but not require, the use of paper filter tests as part of the lead screening requirement.
- The PCP should inform members of all testing/ screenings due in accordance with the periodicity schedule specified on the AHCA website: b.ahca. myflorida.com/medicaid/childhealthservices/ chc- up/index.shtml. The PCP should contact members to encourage them to obtain health assessments and preventive care.
- The PCP (or OB-GYN for pregnant members) should refer members to appropriate service providers within four weeks of the examination for further assessment and treatment of conditions found during the examination.
- The PCP may provide fluoride treatment for children/ adolescents even if the health plan does not provide dental coverage.
- The PCP should offer scheduling assistance and transportation to members to assist them to keep, and travel to, medical appointments.
- The well-child program includes the maintenance of a coordinated system to follow the member through the entire range of screening and treatment, as well as supplying CHCUP training to medical care providers.

- Pursuant to s. 409.975(5), F.S., Humana Healthy Horizons in Florida shall achieve a well-child visit screening rate of at least 80% for those members who are continuously enrolled for at least eight months during the federal fiscal year (Oct. 1 to Sept. 30). This screening compliance rate is based on the CHCUP screening data reported by the PCP and due to the agency by July 1 following the end of each federal fiscal year.
- Humana Healthy Horizons in Florida will adopt annual screening and participation goals to achieve at least an 80% well-child visit screening and participation rate. For each federal fiscal year that the Humana Healthy Horizons in Florida Provider Network does not meet the 80% screening and participation rate, Humana Healthy Horizons in Florida must submit quarterly updates in the Performance Measure Action Plan (PMAP) to the agency.

Provider complaints

A provider complaint, whether claims related or non- claims related, may be filed verbally or in writing. Upon receipt of a complaint, the assigned Provider Complaint Resolution team will investigate each complaint applying any applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying Humana Healthy Horizons in Florida's written policies and procedures. The Provider Complaint Resolution team will contact the provider and/or provider's office to research and resolve the issue within the timeframe identified in the table below, titled "Complaint Q&A."

A provider complaint may be filed using the following steps:

Verbal complaint

To submit a verbal complaint, please call Humana Healthy Horizons in Florida Provider Services at **800-477-6931**.

A customer service specialist (CSS) will receive the initial call and attempt to resolve any issues or concerns at the time of the call. If the provider requests to file a complaint, the CSS will log the details in the tracking system. If the CSS cannot provide immediate resolution, notes will be added to the entry and the caller will be transferred to the correct Provider Complaint Resolution team.

With a verbal complaint, the provider will receive a verbal acknowledgement of the complaint followed up by a written acknowledgement letter within three business days, which is documented in our tracking system. If the complaint is resolved on the call, the provider will receive a written disposition letter within three business days. If the complaint

is not resolved on the call, the provider will receive an acknowledgement letter, status letters as necessary and a disposition letter once resolved, as detailed in Complaint FAQ below.

Written complaint

Please submit written complaints via email for faster resolution

Long-term services and supports (LTSS): FLResolutionLTSS@humana.com

Managed medical assistance (MMA): FLMedicaidResolution@humana.com

Providers may still submit complaints in writing via mail by using this address:

Humana Healthy Horizons in Florida
Provider Correspondence
P.O. Box 14601
Lexington, KY 40512-4601

Claims complaints FAQ

Topic	Response

How can complaints be submitted?	In writing to: **Humana Healthy Horizons in Florida** **Provider Correspondence – Complaint** **P.O. Box 14601** **Lexington, KY 40512-4601** Electronic requests may be sent to: **FLMedicaidResolution@humana.com** Or call **800-477-6931**
What is the time frame for a provider to submit a complaint?	**Claims-related:** Within 90 days of the date of the final determination of the primary payer **Non-claims related:** Within 45 days of the date the issue occurred
What communication can be expected?	**Written complaints:** Acknowledgement letter, within three business days of receipt of the complaint Status letters, sent on the 15th day and every 30 days until resolved Disposition letter, within three business days of resolution **Verbal complaints:** Acknowledgement letter, within three business days of the call Status letters, sent on the 15th day and every 30 days until resolved Disposition letter, within three business days of resolution
What is the resolution time frame?	**Claims complaints:** Within 60 days after the receipt of the complaint for complaints related to claim denials, unless the claim is under active review by a mediator, arbitrator or third- party dispute entity. Within 90 days after the receipt of the complaint for all other claim complaints, unless the claim is under active review by a mediator, arbitrator or third-party dispute entity. **Non-claims complaints:** Within 90 days of receipt of the complaint
What is the timeframe for provider to submit a claim for overpayment?	Provider shall report to Humana Healthy Horizons in Florida when he/she receives an overpayment within 60 days after the date on which the overpayment was identified, and must notify Humana in writing of the reason for the overpayment, as required by 42 CFR 438.608(d)(2), to be mailed to: **Humana Healthcare Plans** **P.O. Box 931655** **Atlanta, GA 31193-1655**

Grievance system

The section below is taken from Humana Healthy Horizons in Florida's member grievance and appeal procedure as set forth in the Humana Healthy Horizons in Florida Member Handbook. This information is provided to you so that you may assist Humana members in this process, should they request your assistance. Please contact your provider contracting representative should you have questions about this process.

Humana has representatives who handle all member grievances and appeals. A special set of records is kept with the reason, date and results. Humana keeps these records in its central office.

Filing a grievance or an appeal

If a member has questions or an issue, he or she may call Humana Healthy Horizons in Florida Member Services at **800-477-6931 (TTY: 711),** Monday – Friday, 8 a.m. and 8 p.m., Eastern time.

If a member is not happy with the answer he or she receives from customer service, a member can file a grievance or appeal. A member can call customer service to file a complaint, grievance or an appeal. If a member calls about a complaint and it remains unresolved by the next day's close of business, Humana will automatically start its grievance process. If Members would like to file a complaint, grievance or appeal they may send Humana Healthy Horizons in Florida a letter, obtain a form from the Humana Healthy Horizons in Florida website or file verbally by calling customer service. A member can also request that Humana provide assistance with completion of the form.

All grievances or appeals will be considered. The member can have someone help during the process, whether it is a provider or someone he or she chooses. The member has the right to continue services during the grievance or appeal process. If the member would like his/ her services to continue, the member must submit an appeal within 10 calendar days after the date on the notice of action; or on or before the intended effective date of action, whichever is later. However, if the appeal decision is not in the member's favor, the member may have to pay for those services.

The grievance or appeal must have the following:

- Name, address, telephone number and ID number
- Facts and details of what actions were taken to correct the issue
- What action would resolve the grievance or appeal
- Signature
- Date

Grievance: The member has the right to submit a written or verbal grievance. The grievance process may take up to 90 days. However, Humana will resolve the member's grievance as quickly as his or her health condition requires. A grievance outcome letter will be sent within 90 days from the date the grievance is received. The member can request a 14-day extension if needed; Humana also may request an extension if additional information is needed and is in the member's best interest. Humana will send the member notice of the extension with details regarding any needed information and how the member's best interest is served by the additional time.

Florida Medicaid Grievance First-Level Review

Topic	Response
In what manner may the grievance be submitted?	Oral or written
What is the time frame to submit the grievance?	Unlimited
Is an appointment of representation (AOR) required?	Yes
Is an acknowledgment of the grievance required?	Yes, within five business day of receipt

What is the resolution time frame?	No later than 90 calendar days of receipt

Appeal: A member must file the appeal either verbally or in writing within 60 calendar days of the date on the notice of adverse benefit determination. The date of the oral notice will be considered the date of receipt. Humana will resolve the appeal as quickly as the health condition requires. A letter telling the member the outcome of the appeal will go out within 30 days from the date Humana receives the request. The member can request a 14-day extension if needed. Humana can also request an extension if additional information is needed and is in the member's best interest. Humana will inform the member of any extra time needed to make a decision, what additional information is needed, and why it is in the member's best interest.

Florida Medicaid Appeal First-Level Review Determination

Topic	Response
In what manner may the appeal be submitted?	Oral or written
What is the time frame to submit the appeal?	Within 60 days from the date of the notice of adverse benefit determination
Is an appointment of representation (AOR) required?	Yes
Is an acknowledgment of the appeal required?	Yes, within five business days of the appeal receipt
What is the decision notification method?	Written
What is the decision timeframe?	Appeal determinations should be rendered as expeditiously as the member's health condition requires but no later than 30 calendar days from receipt, whether received orally or in writing.

Expedited process: The member has the right to make an expedited verbal or written appeal. If there is a problem that is putting the member's life or health in danger, the member or the member's legal spokesperson can file an "urgent" or "expedited" appeal. These appeals are handled within 48 hours. When making an appeal, the member or member's legal spokesperson needs to let Humana know that this is an "urgent" or "expedited" appeal. An expedited appeal may be made by calling Humana at 888-259-6779. If it is determined that an expedited process is not required, it will go through the normal process.

Humana shall not discriminate against **provider** or take punitive action against a provider who requests an expedited resolution or supports a member's appeal, as required by 42 CFR 438.410(b).

Florida Medicaid Expedited Appeal First-Level Review

Topic	Response
In what manner may the appeal be submitted?	Oral or written
What is the time frame to submit the appeal?	Within 60 calendar days from the date of the notice of action
Is an appointment of representation (AOR) required?	Yes, except from the provider

Is an acknowledgment of the appeal required?	Yes, oral acknowledgment is required no later than 24 hours of receipt
What is the decision time frame?	As expeditiously as the member's health condition requires but not to exceed 48 hours after receipt, whether the request was submitted orally or in writing

Medicaid fair hearing: If a member is not happy with Humana's appeal decision, he or she can ask for a Medicaid fair hearing. A member may only seek a Medicaid Fair Hearing after exhausting Humana's internal appeal process. The member has 120 days from the date of the appeal resolution to request a Medicaid Fair Hearing. The addresses and phone numbers for Medicaid Fair Hearings at the local Medicaid area offices can be found at: **portal.flmmis.com/FLPublic/Provider_ContactUs/tabId/38/Default.aspx**

They are as follows:

Agency for Healthcare Administration
Medicaid Hearing Unit
P.O. Box 60127
Fort Myers, FL 33906

Call toll free: 877-254-1055 Fax: 239-338-2642

Email: **MedicaidHearingUnit@ahca.myflorida.com**

The member has the right to continue to receive benefits during a Medicaid Fair Hearing. He or she can request to continue to receive benefits by calling our Member Services department at **800-477-6931 (TTY: 711)**, Monday – Friday, 8 a.m. and 8 p.m., Eastern time If the decision is not in the member's favor, he or she may have to pay for those benefits. The member has the right to review his or her case before and during the appeal process.

To send a grievance or appeal request in writing, the member may mail it to the following address:

Humana Healthy Horizons in Florida
P.O. Box 14546
Lexington, KY 40512-4546

If the member wants to contact our Member Services department by phone, he or she can call **800-477-6931 (TTY: 711)**.

If the member cannot hear or has trouble talking, he or she may call **800-833-3301**. Member Services department hours are 8 a.m. to 8 p.m. local time, Monday through Friday.

If the member is calling after-hours, weekends or holidays for an urgent/expedited grievance or appeal, he or she will be asked to leave a voicemail and will receive a callback by the end of the following day by a specialized team to address the expedited grievance or appeal.

Chronic and complex conditions

Comprehensive diabetes care

Diabetic retinal examinations: Humana is committed to reducing the incidence of diabetes-induced blindness for Humana Healthy Horizons in Florida members. Early intervention and continual monitoring of diabetic eye disease could reduce the incidence of diabetes-related blindness. Based on guidelines proposed by the American College of Physicians, the American Diabetic Association and the American Academy of Ophthalmology, the Humana Healthy Horizons in Florida PCP will provide or manage services such that recipients with a history of diabetes will receive at least one fundoscopic exam every 12 months.

Glycohemoglobin levels: Humana acknowledges that tight control of blood glucose levels can delay the onset and slow the progression of many of the side effects of diabetes. Glycohemoglobin is one laboratory indicator of how well a member's blood sugar is controlled. Consistent with the American Diabetic Association recommendations, the Humana Healthy Horizons in

Florida PCP will provide or manage services such that members with a history of diabetes will receive glycohemoglobin determinations at least twice a year.

Lipid levels: Humana recognizes the direct link between hyperlipidemia, secondary hyperlipoproteinemias and diabetes mellitus. By closely monitoring lipids and lipoprotein levels in diabetics, better control and maintenance of diabetes is possible. Consistent with the recommendations of the American Diabetes Association, the Humana Healthy Horizons in Florida PCP will provide or manage services such that members with a history of diabetes will receive lipid and lipoprotein determination annually. If anomalies are found in the annual baseline, additional studies should be conducted as medically necessary.

Nephropathy

The Humana Healthy Horizons in Florida PCP screening for nephropathy is to delay or prevent loss of renal function through early detection and initiation of effective therapies, and to manage complications in those identified with a renal disease. The PCP will manage the member by identifying evidence of a positive test for protein in the urine (microalbuminuria testing). Member is to be monitored for the disease, including end-stage renal, chronic renal failure, renal insufficiency or acute renal failure, and referred to a nephrologist as deemed medically appropriate.

Congestive heart failure

Humana is aware there are effective options for treating heart failure and its symptoms. Humana recognizes that with early detection, symptoms can be reduced, and many heart failure patients are able to resume normal active lives. To further these goals, the Humana Healthy Horizons in Florida PCP will provide or manage care of the CHF member by prescribing and monitoring an angiotensin-converting enzyme (ACE) inhibitor, angiotensin II receptor blockers (ARB) and diuretic and reviewing the contraindications of those medications prescribed. An echocardiogram should be performed annually, and the member should be instructed on nutrition and education ongoing of his or her disease.

Asthma

Humana recognizes that asthma is a common chronic condition that affects children and adults. The PCP is expected to measure the member's lung function and assess the severity of asthma and to monitor the course of therapy based on the following:

1. Educate the member about the contributing environmental control measures to avoid or eliminate factors that precipitate asthma symptoms or exacerbations.
2. Introduce comprehensive pharmacologic therapy for long-term management designed to reverse and prevent the airway inflammation characteristic of asthma as well as pharmacologic therapy to manage asthma exacerbations.
3. Facilitate education that fosters a partnership among the member, his or her family and clinicians.

Hypertension

Humana recognizes that PCPs can assist members by checking blood pressure at every opportunity and by counseling members and their families about preventing hypertension. Members would benefit from general advice on healthy lifestyle habits, in particular, healthy body weight, moderate consumption of alcohol and regular exercise. The PCP is expected to document in each member's medical record the confirmation of hypertension and identify if the member is at risk for hypertension.

HIV/AIDS

Humana Healthy Horizons® in Florida requires that PCPs assist members in obtaining necessary care in coordination with Humana Health Services staff. Please contact health services at **800-229-9880**, or your provider contract representative for more details.

Tuberculosis

Humana shall be responsible for the care for members who have been diagnosed with tuberculosis disease, or show symptoms of having tuberculosis and have been designated a threat to the public health by the Florida Department of Health (FDOH) Tuberculosis Program and shall observe the following:

1. Said members shall be hospitalized and treated in a hospital licensed under Chapter 395 F.S. and under contract with the FDOH pursuant to 392.62, Florida Statutes;
2. Treatment plans and discharge determinations shall be made solely by FDOH and the treating hospital;

3. For members determined to be a threat to public health and receiving tuberculosis treatment at an FDOH contracted hospital, the managed care plan shall pay the Medicaid per diem rate for hospitalization and treatment as negotiated between Florida Medicaid and FDOH, and shall pay any wrap-around costs not included in the per diem rate; and
4. Reimbursement shall not be denied for failure to prior authorize admission, or for services rendered pursuant to 392.62 F.S.

Telephonic Medicaid disease management program

The goals of the Medicaid disease management program provided by Humana Healthy Horizons in Florida:

- Improve members' understanding and assist self- management of their disease with education and support while following their doctor's plan of care
- Help members maintain optimal disease management and mitigate potential comorbidities using interventions to influence behavioral changes
- Increase member compliance and disease-specific knowledge with plan of care via mailed materials, recommended websites and newsletters
- Ensure timely medical/psychological visits and appropriate utilization of access to care to include the use of home healthcare services
- Find and obtain community-based resources that meet the member's medical, psychological and social needs
- Develop routine reporting and feedback loops that may include communications with patients, physicians, health plan and ancillary providers via telephonic contact and secure fax progress notes
- Provide proactive health promotion education to increase awareness of the health risks associated with certain personal behaviors and lifestyles
- Evaluate clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall population health of disease management program members

Disease management case managers with a nursing license are selected based on demonstrated skills in classifying, assessing, monitoring, evaluating, instructing, intervening and documenting goals and outcomes of members with:

- Asthma
- Cancer
- Diabetes
- Congestive heart failure
- Hypertension
- HIV+/AIDS
- Mental health
- Adult/Pediatric asthma
- Substance abuse
- COPD
- ESRD/CKD
- Sickle Cell Disease

Member eligibility is based on a member having one or more of the above diagnoses. The disease management program provides services that include, but are not limited to:

- Evaluating member needs that can affect control of their disease such as physical limitations, mental health effects, transportation difficulties and environmental needs
- Developing self-management goals and plan of care considering members' health history, psychosocial assessment, providers' plan of care and members' needs
- Educating on diagnosis and potential treatment modalities
- Referring to internal and external programs
- Supporting members and providers regarding diagnosis, plan of care and other health-related concerns
- Educating and assisting members on reaching disease- specific diet and exercise goals
- Educating members on recommended health checks

The member may contact the PCP to request a disease management program referral or may call Humana at **800-229-9880** for

a self-referral.

Referrals also are generated by claims data, on-site and telephonic nurses after discharge, PCPs, internal and external programs and community partners.

To obtain more information about the program, refer a member, provide feedback or file a complaint for

disease management, please call **800-229-9880**. Hours of operation are 8:30 a.m. to 5 p.m., Eastern time, Monday through Friday, or visit Humana.com. Enrollment or disenrollment from this program is voluntary.

Complex case management: Complex case management is a service provided to Medicaid members by Humana nurses specially trained in case management. Their specialized focus is on members with complex medical needs. Management is designed to meet the medical and psychosocial needs of the member and varies depending on situation and severity. A multidisciplinary team approach is utilized to ensure the member's needs are met and all efforts are made to improve and optimize his/her overall health and well-being. A team of physicians, social workers and community services partners are on hand to help make sure members' needs are met and all efforts are made to improve and optimize their overall health and well-being. The case management program is optional.

To refer Medicaid members and verify program eligibility, please call the health services department at **800-229-9880**.

Quality improvement (QI) program: Humana's quality improvement program includes clinical care, preventive care and member services.

Utilization management (UM): Humana wants to ensure its members receive the right medical care from the right provider at the right time. Humana works with practitioners and providers to deliver services that are correct and medically needed for a member's medical condition. UM decision-making at Humana is based only on appropriateness of care and service and existence of coverage.

- Humana does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

If you have questions or concerns related to utilization management, staff is available from 8:30 a.m. to 5 p.m., Eastern time, Monday through Friday, by calling **800-393-8858 (TTY: 711).**

You can obtain copies of criteria used to make UM decisions by calling **800-223-6447**, Monday through Friday.

Language assistance is available at no cost.

PCP and other provider/subcontractor responsibilities

Access to care

Participating PCPs and specialists are required to ensure adequate accessibility for healthcare 24 hours per day, seven days per week (24/7). An after-hours telephone number must be available to members (voicemail is not permitted). The member should have access to care for PCP services and the PCP's (or OB-GYN for pregnant members) should submit referrals to the plan so the member can see specialists for medical and behavioral health services available on a timely basis, as follows:

Appointments for urgent medical or behavioral healthcare services shall be provided:

- Within 48 hours of a request for medical or behavioral healthcare services that do not require prior authorization.
- Within 96 hours of a request for medical or behavioral healthcare services that do require prior authorization.

Appointments for non-urgent care services shall be provided:

- Within seven days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.
- Within 14 days for initial outpatient behavioral health treatment.
- Within 14 days of a request for ancillary services deemed necessary for the diagnosis or treatment of injury, illness or other health condition.
- Within 30 days of a request for a primary care appointment

- Within 60 days of a request for a specialist appointment after the appropriate referral is received by the specialist.
- Within 30 days of an Individualized Family Support Plan (IFSP) was completed for children enrolled in the Early Steps Program to receive early intervention services.

The PCP (and/or OB-GYN for pregnant members) provides, or arranges for, coverage of services, consultation or approval for referrals 24/7 by Medicaid-enrolled providers who will accept Medicaid reimbursement. This coverage shall consist of an answering service, call forwarding, provider call coverage or other customary means approved by the agency. The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hours coverage must be accessible using the medical office's daytime telephone number. The PCP arranges for coverage of primary care services during absences due to vacation, illness or other situations that require the PCP to be unable to provide services. A Medicaid-eligible PCP must provide coverage.

A PCP will need to submit referrals when necessary, for members to see specialists for care. Referrals can be submitted or requested in the following ways:

- By calling 1-866-856-8974
- By faxing a request to: 813-321-7220 or
- By submitting a referral through Availity Essentials™

OB-GYNs may submit referrals to specialists when necessary, for pregnant members they are seeing.

Americans with disabilities act (ADA)

All Humana-contracted healthcare providers must comply with the ADA, as well as all applicable state and/or federal laws, rules and regulations. More details are available in the Humana provider agreement under "Compliance with Regulatory Requirements."

Humana develops individualized care plans that take into account members' special and unique needs.

Healthcare providers with members who require interpretive services may contact the Humana Concierge Service for Accessibility at **877-320-2233**.

Members who need interpretation services can call the number on the back of their member ID cards, Humana Concierge Service for Accessibility at **877-320-2233**, or visit Humana's website at: **www.humana.com/legal/accessibility-resources**

Transition/coordination of care of new members

There will be coordination of care for new members transitioning into the managed care plan. In the event a new member is receiving a prior-authorized ongoing course of treatment with any provider, the managed care plan shall be responsible for the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or nonparticipating providers. Providers shall be reimbursed at the rate they received for services immediately prior to the member transitioning for a minimum of 30 days.

Humana Healthy Horizons in Florida shall provide continuation of MMA services until the member's PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the

member's treatment plan, which shall be no more than 60 calendar days after the effective date of enrollment.

Providers should continue providing services to members during the 60-day continuity of care period for any services that were previously authorized or prescheduled prior to the implementation, regardless of whether the provider

is participating in Humana Healthy Horizons in Florida's network.

Providers should keep previously scheduled appointments with new members during the transition.

The following services may extend beyond the continuity of care period with the member's current provider:

- Prenatal and postpartum care
- Transplant services (through the first year post- transplant)
- Radiation and/or chemotherapy services (for the current round of treatment)

- If the services were arranged prior to enrollment with the plan, written documentation includes the following:
- Prior existing orders
- Provider appointments (e.g., dental appointments, surgeries, etc.)
- Prescriptions (including prescriptions at nonparticipating pharmacies)
- Behavioral health services

Although no additional authorization is needed for any ongoing treatment, written documentation for the provision of continued services may be needed for proper payment of the provided services.

Through the following process, we will ensure that transitioning members will still receive care even if Humana does not have a contract with the member's current provider:

- Continue care plan as is for up to 60 days
- Ensure there are no care disruptions
- Emphasize the member's comfort and safety while addressing unmet needs
- Contract with nonparticipating providers
- Reassess and update the personalized plan of care
- Identify members who desire to transition/continuity of care
- Determine unmet needs and put necessary services in place
- Coordinate and build relationships with providers
- Put the member with a new case manager

Family planning services

AHCA requires that family planning services be furnished on a voluntary and confidential basis.

Family planning services and supplies

- Humana Healthy Horizons in Florida provides family planning services to help members make comprehensive and informed decisions about family size and/or spacing of births. The following services are provided: planning and referral, education and counseling, initial examination, diagnostic procedures and routine laboratory studies, contraceptive drugs and supplies, and follow-up care in accordance with the Medicaid Practitioner Services Coverage and Limitations Handbook.
- This information should be documented in the patient's medical record to meet the contractual requirement. Humana or AHCA may audit your medical records to confirm compliance with this contractual clause.
- Members can choose from any Medicaid doctor for family planning services. Prior approval is not needed.

Please note: The above content is informational only and does not constitute clinical advice or recommendations. This information is not intended to interfere with, or prohibit, clinical decisions made by prescribers or communication between prescribers and patients regarding clinical care and all available options.

Immunizations

As part of Humana Healthy Horizons in Florida's focus on preventive health, we want all infants and children to receive recommended immunizations and screenings. Additionally, as detailed under section 1905(r)(1)(B)(iii) of the Social Security Act, we want to remind you of your participation in the Vaccines for Children (VFC) program and the benefits of the VFC program.

The VFC program provides vaccines at no charge to physicians and eliminates the need to refer children to county health departments for immunizations. Humana Healthy Horizons in Florida is enrolled as a data partner with Florida SHOTSPTMP. Additional information regarding ordering VFC program vaccines is available on the Florida SHOTSPTMP website at **flshotsusers.com.**

Important notes:

- Healthcare providers can verify their participation in the VFC program at the following link: **https://www.floridahealth.gov/programs-and-services/immunization/vaccines-for-children/active-vfc-providers.html**
- Also, it's important for providers to maintain an adequate vaccine inventory. The below link provides useful

information for this process: **https://flshotsusers.com/sites/default/files/inline-files/Return%20and%20Waste%20January%202016_508.pdf**

- Humana Healthy Horizons in Florida may reimburse the cost of the vaccine and an administration fee for Medicaid-eligible recipients 0 to 18 years of age who receive vaccines not available through the VFC program.
- Guidelines on how you should bill for the vaccination administration and vaccines can be found at: **https://ahca.myflorida.com/medicaid/review/Reimbursement/2022-01-01_Fee_Sched_Billing_Codes/Prescribed_Drugs_Immunization_Fee_Schedule_2022.pdf**
- Providers must cooperate with all requests for immunization records for members from any local or federal agency, including the Florida DCF.

Please note: Immunizations should be provided in accordance with the Recommended Childhood Immunization Schedule for the United States or when medically necessary for the member's health, as determined by the physician.

Adult health screening

Adult preventive health exam – Beginning at age 21

Elements	Guidelines
1. Risk screening	Screening to identify high-risk individuals, assessing family medical and social history is required. Screening for the following risks are to be included as a minimum: cardiovascular disease, hepatitis, HIV/AIDS, STDs and TB.
2. Interval history	Interval histories are required with preventive healthcare. Changes in medical, emotional and social status are to be documented.
3. Immunizations	Immunizations are to be documented and current. If immunization status is not current, this is to be documented with a catch-up plan. Immunizations are required as follows: influenza, annually beginning at age 65 years, Td booster every 10 years; pneumococcal vaccine beginning at age 65. When an individual has received a pneumococcal vaccination prior to the age of 65 years and it has been five years since the vaccination, the individual should be revaccinated.
4. Height and weight	Documented height and weight is required for all preventive healthcare visits and at least: – every five years for ages 21 to 40 every two years beginning at age 41
5. Vital signs	Pulse and blood pressure are required for all preventive healthcare visits and at least: – every five years for ages 21 to 40 every two years beginning at age 41
6. Physical exam	Appropriate evaluation for inclusion in the baseline physical examination of an asymptomatic adult are: – General appearance – Skin – Gums/dental/oral – Eyes/ears/nose/throat – Neck/thyroid – Chest/lungs – Cardiovascular – Breasts – Abdomen/GI – Genital/urinary – Musculoskeletal – Neurological – Lymphatic If noncompliance or refusal is documented, the risk associated with the noncompliance must be documented.

7. Cholesterol screening	Screening required every five years for: – Men, beginning age 35 – Women, beginning age 45 (Earlier if there is any risk factor evident for cardiovascular disease)
8. Visual acuity testing	Visual acuity testing, at a minimum, is to document the patient's ability to see at 20 feet. Referrals for testing must be documented.
9. Hearing screening	Test or inquire about hearing periodically/once a year.
10. Electrocardiogram	Periodically after ages 40 to 50 (or as primary care deems medically appropriate).
11. Colorectal cancer	Colorectal cancer screening must be documented Screening beginning at age 50. **Risk factors:** First-degree relatives or personal history of colorectal cancer, personal history of female genital or breast cancer, familial adenomatous polyposis, Gardner syndrome, hereditary nonpolyposis colon cancer, chronic inflammatory bowel disease.
12. Pap smear	Baseline pap smears are required annually for three consecutive years until three consecutive normal exams are obtained; then every two to three years. May stop at age 65 if patient had regularly normal smears up to that age.
13. Mammography	Required as appropriate between ages 35 and 40: – Every one to two years for women age 40 or older Earlier and/or more frequent for women at high risk
14. Prostate exam/ screening	**U.S. Preventive Services Task Force, December 2002:** Evidence is insufficient to recommend for or against routine screening for prostate cancer using PSA testing or digital rectal examination. The USPSTF found evidence that PSA can detect early-stage prostate cancer but mixed and inconclusive evidence that would suggest early detection improves health outcomes. There was insufficient evidence to determine whether the benefits outweigh the harms (of biopsies, complications and anxiety), especially in a cancer that may have never affected the patient's health. **American College of Physicians 2004:** Recommendations are for selected testing in 50- to 69-year-olds provided that the risks, benefits and uncertainties are understood. Current available evidence suggests it is difficult to justify routine screening of men 70 and older.
15. Education/ anticipatory guidance	Health education and guidance must be documented. Educational needs are based on risk factors identified through personal and family medical history and social and cultural history and current practices.
16. Osteoporosis	Screening for women age 65 and older is required; begin at age 60 if at increased risk for osteoporotic fractures. Perform DEXA scan for serial monitoring every two years; special conditions may need more frequent monitoring. All perimenopausal women should have a DEXA scan after a fracture, if test has not been performed recently.

Hysterectomies, sterilizations and abortions

Participating providers must acquire a signed form from the patient and submit with the claim for processing per state guidelines.

Required forms can be found at the following links:

- Abortion Certification Form - **https://www.flrules.org/gateway/readRefFile.asp?refId=7013&filename=AHCA%20MedServ%20Form%20011_June%202016.pdf**
- Sterilization Consent Form - **https://ahca.myflorida.com/medicaid/review/Forms/consent-for-sterilization- english-2025.pdf**
- Hysterectomy Consent Form - **https://www.flrules.org/gateway/readRefFile.asp? refId=7015&filename=HAF-5000_**

June%202016.pdf

- Exception to Hysterectomy Acknowledgment Requirement Form – **https://www.flrules.org/gateway/readRefFile.asp? refId=7014&filename=ETA-5001_June%202016.pdf**

This form MUST be on file before claim will be paid.

Healthy Start services

Providers treating members who are pregnant should offer Florida's Healthy Start prenatal risk screening to each pregnant member as part of her first prenatal visit. Providers conducting such screening must use the DOH prenatal risk form (DH Form 3134), which can be obtained from the local CHD. One copy of the completed screening form should be kept in the member's medical record, and another copy should be provided to the member. Within 10 business days of completion, the provider must submit the screening form to the CHD in the county in which the prenatal screen was completed. Providers shall ensure that they document the member's preterm delivery risk assessment within the member's medical record by no later than week 28.

Participating hospitals and birthing centers also should complete the Florida Healthy Start Infant Postnatal Risk Screening Instrument (DH Form 3135) with the Certificate of Live Birth and transmit both documents to the CHD in the county in which the infant was born within five business days of completion. Copies of Form 3135 should be maintained by the provider, included in the member's medical record and furnished to the member. Humana contacts participating hospitals and birthing facilities to determine if they participate in the DOH electronic birth registration system. If Humana determines that the hospital or birthing facility did not file the required birth information within the required time frame, the hospital and birthing facility is educated regarding the proper process and associated timeliness standards. Humana preforms an annual audit on these requirements with the hospital and birthing center for compliance and implements a Corrective Action Plan as needed.

If the provider determines that the member's pregnancy is high risk, the provider shall ensure that the obstetrical care during labor and delivery includes preparation by all attendants for symptomatic evaluation and that the member progresses through the final stages of labor and immediate postpartum care. The provider shall notify the health plan immediately of a member's pregnancy, which can be identified through medical history, examination, testing, and claims or otherwise.

Pregnant members or infants who do not score high enough to be eligible for Healthy Start care coordination may be referred for services, regardless of their score on the Healthy Start risk screen, in the following ways:

1. If the referral is to be made at the same time the Healthy Start risk screen is administered, the provider may indicate on the risk screening form that the member or infant is invited to participate based on factors other than score; or
2. If the determination is made subsequent to risk screening, the provider may refer the member or infant directly to the Healthy Start care coordinator based on assessment of actual or potential factors associated with high risk, such as HIV, hepatitis, hepatitis B, substance abuse or domestic violence.

Provider should refer all pregnant women, breast-feeding and postpartum women, infants and children up to age 5 to the local WIC office:

1. The participating provider of Humana Healthy Horizons in Florida should provide:
    a. A completed Florida WIC program medical referral form with the current height or length and weight (taken within 60 calendar days of the WIC appointment);
    b. Hemoglobin or hematocrit test results; and
    c. Documentation of any identified medical/nutritional problem.
2. For subsequent WIC certifications, providers should coordinate with the local WIC office to provide the above referral data from the most recent CHCUP.
3. Each time the participating provider completes a WIC referral form, the provider should give a copy of the WIC referral form to the member and retain a copy in the member's medical record.

Providers must provide all women of childbearing age HIV counseling and offer them HIV testing.

1. In accordance with Florida law, providers should offer all pregnant women counseling and HIV testing at the initial prenatal care visit and again at 28 and 32 weeks.

2. Providers must attempt to obtain a signed objection if a pregnant woman declines an HIV test.
3. All pregnant women who are infected with HIV should be counseled about and offered the latest antiretroviral regimen recommended by the U.S. Department of Health and Human Services.
4. Providers must screen all pregnant members receiving prenatal care for the hepatitis B surface antigen (HBsAg) during the first prenatal visit.
5. Providers must perform a second HBsAg test between 28 and 32 weeks of pregnancy for all pregnant members who tested negative at the first prenatal visit and are considered high-risk for hepatitis B infection. This test should be performed at the same time other routine prenatal screening is ordered.
6. All HBsAg-positive women should be reported to the local CHD and to Healthy Start, regardless of their Healthy Start screening score.

Participating providers should ensure that infants born to HBsAg-positive members should receive hepatitis B immune globulin (HBIG) and the hepatitis B vaccine once they are physiologically stable, preferably within 12 hours of birth, and should complete the hepatitis B vaccine series according to the recommended vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States.

1. Providers should test infants born to HBsAg-positive members for HBsAg and hepatitis B surface antibodies (anti-HBs) six months after the completion of the vaccine series to monitor the success or failure of the therapy.
2. Providers must report to the local CHD a positive HBsAg result in any child age 24 months or younger within 24 hours of receipt of the positive test results.
3. Participating providers should ensure that infants born to members who are HBsAg-positive are referred to Healthy Start, regardless of their Healthy Start screening score.

Participating providers should report to the perinatal hepatitis B prevention coordinator at the local CHD all prenatal or postpartum members who test HBsAg-positive. Participating providers also should report said members' infants and contacts to the perinatal hepatitis B prevention coordinator at the local CHD.

1. The participating provider should report the following information about the mother: name, date of birth, race, ethnicity, address, contacts, laboratory test performed, date the sample was collected, the due date or estimated date of conception (EDC), and whether or not the member received prenatal care and immunization dates for infants and contacts.
2. The participating provider should use the perinatal hepatitis B Case and Contact Report (DH Form 2136) for reporting purposes. Chapters 381, F.S., 2004. Sections 384.31, F.S., 2004 and 64D-3.019, F.A.C., 2004.
3. U.S. Department of Health & Human Services, Public Health Service Task Force report entitled "Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States."
4. PCPs must maintain all documentation of Healthy Start screenings, assessments, findings and referrals in the members' medical records.

Participating providers should provide the most appropriate and highest level of quality care for pregnant members, including, but not limited to, the following:

1. Prenatal care — Participating providers of Humana Healthy Horizons in Florida are expected to:
    a. Require a pregnancy test and a nursing assessment with referrals to a provider, PA or ARNP for comprehensive evaluation;
    b. Require case management through the gestational period according to the needs of the member;
    c. Require necessary referrals and follow-up;
    d. Schedule return prenatal visits at least every four weeks until the 32nd week, every two weeks until the 36th week, and every week thereafter until delivery unless the member's condition requires more frequent visits;
    e. Contact as soon as possible those members who fail to keep their prenatal appointments, and arrange for their continued prenatal care;
    f. Assist members in making delivery arrangements, if necessary; and
    g. Ensure that all pregnant members are screened for tobacco use and make available to the pregnant members smoking cessation counseling and appropriate treatment as needed.
2. Nutritional assessment/counseling — Participating providers should supply nutritional assessment and counseling to all pregnant members. In addition, participating providers of Humana Healthy Horizons in Florida are expected to:
    a. Ensure the provision of safe and adequate nutrition for infants by promoting breastfeeding and the use of

breast milk substitutes;
    b. Offer a mid-level nutrition assessment;
    c. Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or physician following the nutrition assessment; and
    d. Document the nutrition care plan in the medical record by the person providing counseling.
3. Postpartum care – Participating providers of Humana Healthy Horizons in Florida are expected to:
    a. Provide a postpartum examination for all members within six weeks after delivery;
    b. Ensure members are supplied with voluntary family planning information, including a discussion of all methods of contraception (see Family Planning Services section); and
    c. Ensure that continuing care of newborns is provided through the CHCUP program component and documented in the child's medical record (see Well- Child Visits section).

Humana has partnered with Healthy Start. The Healthy Start program includes targeted support services that address identified risks. The range of free and voluntary Healthy Start services available to pregnant women, infants and children up to age 3 include:

- Childbirth, breastfeeding and car seat education classes;
- Comprehensive assessment of service needs in light of family and community resources;
- Home visits to provide education and support for breastfeeding, baby weight checks, parenting, immunization information and safe sleep;
- Ongoing coordination to assure access to needed services and support to help families attain their goals; and
- Developmental screening, psychosocial assessments, nutritional education, smoking cessation counseling or referrals as needed.

Humana will refer members to Healthy Start for these services when identified utilizing the Healthy Start Assessment Tool. The tool is used to determine eligibility for enrollment in Healthy Start's Care Coordination Program and is completed by the obstetrician at the initial visit. Eligibility is based on identified risk factors that may affect the health of the pregnancy. The goal of the program is to mitigate those risk factors. Members are automatically eligible when they exhibit one of the criteria that makes them automatically eligible, regardless of the assessment tool score (e.g., homelessness, history of abuse, etc.).

Providers are required to immediately notify Humana of a member's pregnancy by calling **800-322-2758**, whether identified through medical history, examination, testing, claims or otherwise.

If a member becomes pregnant while on the plan, she is requested to call Humana's obstetrics case manager at **800-322-2758**. She should choose a Humana Healthy

Horizons in Florida obstetrician or midwife for her care and make an appointment to see this healthcare provider as soon as possible. She must also notify DCF the pregnancy by calling **866-762-2237**.

Before the last trimester, the member must choose a PCP for the baby. If the baby is enrolled with Humana Healthy Horizons in Florida and she does not choose a PCP for the baby, Humana will select one for her. If Humana selects the PCP and the parent does not want the one selected, they can change the child to another doctor. To select or change the baby's health plan, the member is instructed to call Choice Counseling at **877-711-3662** as soon as possible.

They also must notify the DCF of the birth of the baby by calling **866-762-2237**.

Newborn care

The managed care plan shall make certain that its providers supply the highest level of care for the newborn, beginning immediately after birth. Such level of care shall include, but not be limited to, the following:

- Instilling of prophylactic eye medications into each eye of the newborn;
- When the mother is Rh negative, securing a cord blood sample for type Rh determination and direct Coombs test;
- Weighing and measuring of the newborn;
- Inspecting the newborn for abnormalities and/or complications;
- Administering one-half (0.5) milligram of vitamin K;
- APGAR scoring;

- Any other necessary and immediate need for referral in consultation from a specialty physician, such as the Healthy Start (postnatal) infant screen; and
- Newborn screening services in accordance with s. 383.14, F.S., which outlines the required laboratory screening process to test for metabolic, hereditary and congenital disorders known to result in significant impairment of health or intellect. These required laboratory tests shall be processed through the State Public Health Laboratory. The managed care plan shall reimburse for these screenings at the established

Medicaid rate and must enter into a provider agreement or a contract with the State Public Health Department.

Domestic violence, alcohol and substance abuse and smoking cessation

PCPs should screen members for signs of domestic violence and should offer referral services to applicable domestic violence prevention community agencies. See "Quality Enhancement" Section below.

PCPs should screen members for signs of tobacco, alcohol and substance abuse as a part of prevention evaluation at the following times:

- On initial contact with member
- During routine physical examinations
- During initial prenatal contact

When the member shows evidence of serious overutilization of medical, surgical, trauma or emergency services

- When documentation of emergency room visits suggests the need PCPs should screen and educate members regarding smoking cessation by:
- Making members aware of and recognizing the dangers of smoking
- Teaching members how to anticipate and avoid temptation
- Providing basic information to the member about smoking and successfully quitting
- Encouraging the member to quit
- Encouraging the member to talk about the quitting process

Quality enhancements

Quality enhancements (QE) are defined as certain health- related, community-based services to which Humana Healthy Horizons in Florida and its providers must offer and coordinate access for members. These include children's programs, domestic violence classes, pregnancy prevention, smoking cessation and substance abuse programs. These programs are not reimbursable. In addition to the covered services specified in this section, Humana Healthy Horizons in Florida and its providers should offer QE in community settings accessible to members.

Humana Healthy Horizons in Florida may co-sponsor annual training, provided that the training meets the provider training requirements. Services can be offered in collaboration with agencies such as early intervention programs, Healthy Start coalitions and local school districts.

The provider shall ensure documentation of the member's medical record of referrals to community programs and follow up on the member's receipt of services from community programs.

QE programs shall include, but are not limited to, the following:

1. **Children's programs** — Humana Healthy Horizons in Florida and its providers are required to provide regular general wellness programs targeted specifically toward members from birth to age 5, or make a good faith effort to involve members in existing community children's programs. Children's programs should promote increased use of prevention and early intervention services for at-risk members. Humana will approve claims for services recommended by the early intervention program when they are covered services and medically necessary.
    a. Humana Healthy Horizons in Florida is required to offer annual training to providers who promote proper nutrition, breast-feeding, immunizations, CHCUP, wellness, prevention and early intervention services.
2. **Domestic violence** — Providers must screen members for signs of domestic violence and offer referral services to applicable domestic violence prevention community agencies.
3. **Pregnancy prevention** — Humana Healthy Horizons in Florida and its providers are required to conduct regularly

scheduled pregnancy prevention programs or make a good faith effort to involve members in existing community pregnancy prevention programs, such as the Abstinence Education program. The programs should be targeted toward teen members, but should be open to all members, regardless of age, gender, pregnancy status or parental consent.

4. **Prenatal/postpartum pregnancy programs** — Humana Healthy Horizons in Florida is required to provide regular home visits conducted by a home health nurse or aide, counseling and educational materials, to pregnant and postpartum members who are not in compliance with the health plan's prenatal and postpartum programs.
5. **Smoking cessation** — Humana Healthy Horizons in Florida and its providers are required to conduct regularly scheduled smoking cessation programs as an option for all members or make a good faith effort to involve members in existing community smoking cessation programs. Smoking cessation counseling must be available to all members. Providers should use the Quick Reference Guide to assist in identifying tobacco users and supporting and delivering effective smoking cessation interventions. Copies of the guide may be obtained by contacting:

   DHHS, Agency for Healthcare Research & Quality (AHR) Publications Clearinghouse
   P.O. Box 8547
   Silver Spring, MD 20907-8547 1-800-358-9295
6. **Substance use** — Humana Healthy Horizons in Florida is required to offer substance use screening training to providers. Humana Healthy Horizons in Florida and its providers are required to offer targeted members either community- or plan-sponsored substance use programs.

Quality improvement requirements

Humana will monitor and evaluate provider quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to members through:

Performance improvement projects (PIPs) — Ongoing measurements and interventions, significant improvement to the quality of care and service delivery, sustained over time, in both clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction.

Medical record audits — Medical record reviews to evaluate patterns of complaints regarding poor quality of service, poor quality outcomes and adherence to member record documentation standards.

Performance measures — Data collected on patient outcomes as defined by the Healthcare Effectiveness Data and Information Set (HEDIS®) or otherwise defined by the agency.

Surveys — Consumer Assessment of Health Plans Surveys (CAHPS®)

Peer review — Reviews of provider's practice methods and patterns and appropriateness of care.

Standards for member records:

1. Include the member's identifying information, including name, member identification number, date of birth, gender, and legal guardianship (if any);
2. Include information relating to the member's use of tobacco, alcohol and drugs/substances;
3. Include summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow-up;
4. Reflect the primary language spoken by the member and any translation needs of the member;
5. Identify members needing communication assistance in the delivery of healthcare services;
6. Include copies of any completed consent or attestation form(s) used by the managed care plan or the court order for prescribed psychotherapeutic medication for a child younger than 13 years;
7. All member records shall contain documentation that the member was provided with written information concerning the member's rights regarding advance directives (written instructions for living will or power of attorney), including information on Chapter 765, F.S., and whether the member has executed an advance directive. (42 CFR 438.3(j)(3));
8. Neither the managed care plan, nor any of its providers shall, as a condition of treatment, require the member to

execute or waive an advance directive. (42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5)).

9. OB-GYN provider records shall include a copy of the completed screening instrument in the member record and a copy is provided to the member. Documentation of preterm delivery risk assessments are in the member record by week 28.

Community outreach and provider-based marketing activities

Providers need to be aware of and comply with the following requirements:

1. Healthcare providers may display health-plan-specific materials in their own offices. Providers are permitted to make available and/or distribute Humana Healthy Horizons in Florida marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all managed care plans with which the provider participates. If a provider agrees to make available and/or distribute Humana Healthy Horizons in Florida's marketing materials, it should do so knowing it must accept future requests from other Managed Care plans with which it participates. Providers also are permitted to display posters or other materials in common areas such as the provider's waiting room. Additionally, long-term care facilities are permitted to provide materials in admission packets announcing all managed care plan contractual relationships.
2. Healthcare providers cannot orally or in writing compare benefits or provider networks among health plans, other than to confirm whether they participate in a health plan's network. If a provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.
3. Healthcare providers may announce a new affiliation with a health plan through general advertising (e.g., radio, television, websites). Providers may give their patients a list of health plans with which they contract.
4. Healthcare providers may co-sponsor events, such as health fairs and advertise with the health plan in indirect ways, such as television, radio, posters, flyers and print advertisements.
5. Healthcare providers shall not furnish lists of their Medicaid patients to the health plan with which they contract, or any other entity, nor can providers furnish other health plans' membership lists to the health plan; nor can providers assist with health plan enrollment.
6. For the health plan, healthcare providers may distribute information about non-health-plan specific healthcare services and the provision of health, welfare and social services by the state of Florida or local communities as long as inquiries from prospective members are referred to the member services section of the health plan or the agency's choice counselor/enrollment broker. Providers may refer their patients to other sources of information, such as the managed care plan, the enrollment broker or the local Medicaid area office. They may also share with patients information from the agency's website or CMS's website.

Providers may not:

- Offer marketing/appointment forms
- Make phone calls or direct, urge or attempt to persuade recipients to enroll in the managed care plan based on financial or any other interests of the provider
- Mail marketing materials on behalf of the managed care plan
- Offer anything of value to induce recipients/members to select them as their provider
- Offer inducements to persuade recipients to enroll in the managed care plan
- Conduct health screenings as a marketing activity
- Accept compensation directly or indirectly from the managed care plan for marketing activities.
- Distribute marketing materials within an exam room setting
- Furnish to the managed care plan lists of their Medicaid patients or the membership of any managed care plan

Florida Medicaid provider number

All providers must be eligible for participation in the Medicaid program. If a provider is currently suspended or involuntarily terminated from the Florida Medicaid program whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider.

All providers are required to have a unique Florida Medicaid provider number in accordance with AHCA guidelines. Each provider is required to have an NPI in accordance with Section 1173 (b) of the Social Security Act, as enacted by Section 4707 (a) of the Balanced Budget Act of 1997.

To comply with reporting requirements, Humana Healthy Horizons in Florida submits an electronic data file representing its credentialed and contracted provider network each week.

Having the proper Medicaid enrollment is critical. Incorrect enrollment can affect the way a healthcare provider

or provider group is identified by AHCA and its Choice Counselors, as well as how it is listed in Physician Finder, Humana Healthy Horizons in Florida's online provider directory.

All providers and healthcare professionals must be confirmed active on the AHCA portal on the PML. Physician or healthcare professional must be listed as "Enrollment" or "Limited Enrollment" in the Enrollment Type column and as Active (A) in the Current Medicaid Enrollment Status column.

Indications of proper provider or healthcare professional enrollment include:

- Active listing on the PML on the AHCA portal
- Listing that shows "enrollment" or "limited" in the enrollment-type column
- Active (A) listing in the current Medicaid Enrollment Status column
- Accurate NPI listing related to attending, billing, ordering, prescribing, referring and rendering providers (not applicable to atypical providers) affiliated with the correct Medicaid ID.
- Listing with all active service and/or billing locations, provider type and provider specialty codes associated with its respective NPI and Medicaid ID.
- Provider must bill with the information that is in the AHCA PML. If claims are received with provider information that does not match the applicable active PML record, claims may be: rejected, denied, or subject for recoupment if paid in error.

Please note that CMS defines atypical providers as providers that do not provide healthcare.

AHCA's Provider Enrollment area is available to assist physicians and healthcare professionals with enrollment issues, such as change of address, change of ownership and re-enrollment issues via the AHCA website at **https://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_Enrollment/tabId/42/Default.aspx** Guidelines on how physicians and other healthcare professionals should enroll with Medicaid can be found in the Provider Enrollment Policy, Chapter 2 **https://ahca.myflorida.com/ medicaid/review/General/59G-1.060_Enrollment.pdf**

Provider contracts, credentialing and recredentialing

Humana conducts credentialing and recredentialing activities utilizing the guidelines established by AHCA, CMS and NCQA. Humana credentials and recredentials all licensed independent practitioners including providers, non-providers and facilities with whom it contracts and who fall within its scope of authority and action. Through credentialing, Humana verifies the qualifications and performance of providers and other health care practitioners. A senior clinical staff person is responsible for oversight of the credentialing and recredentialing program.

All providers requiring credentialing should complete the credentialing process prior to the provider's contract effective date, except where required by state regulations. Additionally, a provider will only appear in the provider directory once credentialing is complete. Humana will completely process credentialing applications from all provider types within 60 days of receipt of a completed credentialing applications, including all necessary documentation and attachments, and a signed provider agreement.

Any provider appearing in the provider directory are subject to credentialing and recredentialing. Providers included within the scope of credentialing for Humana Healthy Horizons in Florida include, but may not be limited to the following:

- Medical and osteopathic doctors
- Oral surgeons
- Chiropractors
- Podiatrists

- Dentists
- Optometrists
- Allied health providers, including, APRN, clinical nurse specialists, certified nurse midwives and PAs
- Physical and occupational therapists
- Audiologists
- Speech/Language Therapists/Pathologists
- Other licensed or certified practitioners, including physician extenders, who act as a PCP or those that appear in the provider directory.

Behavioral health providers:

- Psychiatrists and other providers
- Addition medicine specialists
- Doctorial or master's level psychologists who are state certified or licensed
- Master's level clinical social workers who are state certified or licensed
- Master's level marriage and family therapists
- Master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed
- Other behavioral health specialists who are licensed, certified or registered by the state to practice independently

If providers wish to become part of the Humana Healthy Horizons in Florida network and/or request to affiliate providers to their contract, they can:

Visit **Humana.com/Providers** and follow the prompts.

Visit **https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=2357654** for Florida-specific information.

Providers also can contact their local provider contract office.

The following information will be needed for the contracting and credentialing process:

- Physician/practice/facility name
- Service address with phone, fax and email information
- Mailing address, if different than service address
- Tax Identification Number (TIN)
- Specialty
- Medicaid provider number
- National Provider Identifier (NPI)
- Council for Affordable Quality Healthcare (CAQH®) number
- Lines of business (e.g., Medicaid, Medicare, etc.) of interest
- Type of contract (e.g., individual, group, facility)

Healthcare providers must be credentialed prior to network participation to treat Humana Healthy Horizons in Florida members. Additionally, a provider will only appear in the provider directory once credentialing is complete.

CAQH application

Humana is a participating organization with CAQH. You are able to confirm we have access to your credentialing application by completing the following steps:

- Log onto the CAQH website at **proview.caqh.org/.**
- Login utilizing your account information
- Select the Authorization Tab
- Confirm Humana is listed as an authorized health plan; if not, please check the authorized box to add Please include your CAQH provider ID number when submitting credentialing documents. It is essential that all documents are complete and current. Please include copies of the following documents:
- Current Malpractice Insurance Face Sheet

- A current Drug Enforcement Administration (DEA) certificate
    - All Buprenorphine prescribers must have an "X" DEA number
- Explanation of any lapse in work history of 6 months or greater.
- Clinical Laboratory Improvement Amendment (CLIA) certificate, as applicable
- Education Council for Medical Graduates (ECFMG), if foreign medical degree
- If you are acting as a Primary Care Provider, attestation that your total patient load is not more than 3,000 patients
- Disclosure of Ownership, as applicable

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

Practitioner Credentialing and Recredentialing

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

1. Signed and dated credentialing application, including supporting documents
2. Active and unrestricted license in the practicing state issued by the appropriate licensing board
3. Previous five-year work history
4. Current Drug Enforcement Administration (DEA) certificate and/or State Narcotics Registration, as applicable
5. Education, training and experience are current and appropriate to the scope of practice requested
6. Successful completion of all training programs pertinent to one's practice
    a. For M.D.s and D.O.s, successful completion of residency training pertinent to the requested practice type
    b. For Dentists and other providers where special training is required or expected for services being requested, successful completion of training program
    c. Board certification, as applicable
7. Current malpractice insurance coverage at the minimum amount in accordance with Florida laws
8. In good standing with:
    a. Medicaid agencies
    b. Medicare program
    c. Health & Human Services-Office of Inspector General (HHS-OIG)
    d. General Services Administration (GSA, formerly EPLS)
9. Active and valid Florida Medicaid ID number
10. Active hospital privileges, as applicable
11. National Provider Identifier (NPI), as verifiable via the National Plan and Provider Enumerator System (NPPES)
12. Quality of care and practice history as judged by:
    a. Medical malpractice history
    b. Hospital medical staff performance
    c. Licensure or specialty board actions or other disciplinary actions, medical or civil
    d. Lack of member grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall member satisfaction
    e. Other quality of care measurements/activities
13. Disclosure of Ownership
14. Site visit for PCP and OB/GYN providers
15. PCP patient load attestation for all PCP providers

Organizational Credentialing and Recredentialing

The organizational providers to be assessed at credentialed and re-credentialed include, but are not limited to:

- Hospitals

- Home health agencies
- Skilled nursing facilities
- Free standing ambulatory surgery centers
- Hospice providers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting
- Dialysis centers
- Pharmacies
- Physical, occupational therapy and speech language pathology (PT/OT/SLP) facilities
- Rehabilitation hospitals (including outpatient locations)
- Diabetes education
- Portable X-ray suppliers
- Rural health clinics
- Federally qualified health centers
- Urgent care clinics
- Free-standing birthing centers

The following elements are assessed when credentialing organizational providers:

1. Completion of a signed and dated application, signature not more than 180 days
2. Organization is in good standing with:
    a. Medicaid agencies
    b. Medicare program
    c. Health & Human Services-Office of Inspector General (HHS-OIG)
    d. General Services Administration (GSA, formerly EPLS)
3. Organization has been reviewed and approved by an accrediting or certification body
    a. If not accredited or certified, a site survey conducted by a state agency
    b. If not accredited, certified or surveyed by a state agency, Humana will conduct a site survey
4. Copy of facility's state license, as applicable
5. CLIA certificates are current, as applicable
6. Active and valid Florida Medicaid ID number
7. National Provider Identifier (NPI), as verifiable via the National Plan and Provider Enumerator System (NPPES)
8. Disclosure of Ownership

Providers will be informed of the credentials committee's decision within 60 business days of the committee meeting. Recredentialing occurs at least every three years. Some circumstances require shorter recredentialing cycles.

- Humana participates with CAQH®, a nonprofit alliance of leading health plans, networks and trade associations. A catalyst for positive change, CAQH members collectively develop and implement administrative solutions that produce meaningful, concrete benefits — for physicians, allied health professionals, their staffs, patients and plans.
- Humana requires use of CAQH ProView® for gathering credentialing information for all network practitioners.

Humana Network Operations/Credentialing will collect Florida Medicaid numbers for all Medicaid contracted providers at initial credentialing. The Medicaid numbers will be loaded into the credentialing system.

Disclosure of Ownership Addendum for Participation with Humana Health Plans

Humana Network Operations/Credentialing will collect full and accurate disclosure of any financial or ownership interest that the provider, or any principal, partner or major shareholder thereof, may hold in any other Medicaid provider or healthcare related entity or any other entity that is licensed by the state to provide health or residential care and treatment to persons.

Practitioner Office Site Evaluation Tool (POSET)

Network operations, or an agent thereof, will perform periodic office site reviews on all Medicaid contracted PCPs and OB-GYNs. The Humana Site Visit Tool will be used. Verification will include ensuring the statewide consumer call center telephone

number, summary of Florida Patients' Bill of Rights and Responsibilities and consumer assistance notice are posted in the office.

Medicaid Attestation for PCPs

Network operations/credentialing will collect a signed Medicaid attestation from all Medicaid contracted PCPs stating that the total active patient load is no more than 3,000 patients per PCP .

Level II Background Screening

Credentialing will perform a satisfactory Level II background check pursuant to s.409.907, F.S., for all treating providers not currently enrolled in Medicaid's fee-for-service program. Credentialing may verify the provider's Medicaid eligibility through the AHCA electronic background screening clearinghouse at: **https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-central-services/background-screening**.

Sanctions and exclusions

Humana Medical Plan will not contract with any provider who has a record of illegal conduct as identified in Section 435.04, F.S.

Credentialing will report providers suspended or terminated from the Humana Medical Plan to the appropriate authorities (e.g., National Practitioner Data Bank [NPDB], Office of Inspector General [OIG], General Services Administration [GSA] and state licensing board).

Credentialing will conduct regular license monitoring for all Medicaid contracted providers to verify active licensure.

Credentialing will review sanction information for any individual/entity identified above:

- List of Excluded Individuals and Entities (maintained by Office of the Inspector General [OIG]): **exclusions.oig.hhs.gov/**
- State Medicaid Agency Sanctions: **https://apps.ahca.myflorida.com/dm_web/(S(2zjl2xmnpwrmmtg5jukw3fhj))/default.aspx**
- General Services Administration (GSA) Exclusions: **SAM.gov** | Search

Recredentialing

Network providers, including practitioners and organizational providers, are recredentialed at least every three years. As part of the recredentialing process,

Humana considers information regarding performance to include complaints and safety and quality issues collected through the quality improvement program. Additionally, information regarding adverse actions is collected from the NPDB, Medicare and Medicaid Sanctions, CMS Preclusion list, the HHS/OIG and GSA (formerly EPLS), and limitations on licensure.

Practitioner rights

Practitioners have the right to review, upon request, information submitted to support his or her credentialing application to the Humana Credentialing department.

Humana keeps all submitted information locked and confidential. Access to electronic credentialing information is password protected and limited to staff that requires access for business purposes.

Practitioners have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the Credentialing department prior to presentation to the credentialing committee. If information obtained during the credentialing or recredentialing process varies substantially from the application, the practitioner is notified and given the

opportunity to correct information prior to presentation to the credentialing committee.

Practitioners have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing department.

Provider responsibilities

Network providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. Humana will initiate immediate action in the event that the participation criteria no longer are met. Network providers are required to inform Humana 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.

Delegation of credentialing/recredentialing

Humana will only enter into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated or their credentialing verification organization (CVO) follows NCQA standards and successfully passes a pre- delegation audit demonstrating compliance with NCQA standards, federal and state requirements. A pre- delegation audit must be completed prior to entering into a delegated agreement. All pre-assessment evaluations will be performed utilizing the most current NCQA and regulatory requirements. The following will be included (at a minimum) in the review:

- Credentialing and recredentialing policies and procedures
- Credentialing and recredentialing committee meeting minutes
- Credentialing and recredentialing file review

Delegates must be in good standing with Medicaid and CMS. Monthly reporting will be required from the delegated entity, which will be defined in an agreement between both parties.

Reconsideration of credentialing/recredentialing decisions

Humana's Credentials Committee may denial a provider's request for participation based on credentialing criteria. The Credentials Committee must notify a provider of a denial that is based on credentialing criteria and provide the opportunity to request reconsideration of the decision within 30 days of the notification. Reconsideration opportunities are available to a provider if he or she is affected by an adverse determination. To submit a reconsideration request, the following steps apply:

- Mail a reconsideration request to the senior medical director.
- A reconsideration request must be in writing and include any additional supporting documentation.
- Send it to:

  Humana
  Attn: Dr. Shoba Srikantan, M.D. Regional Medical Director
  101 E Main St Louisville, KY 40202

Upon reconsideration, the Credentials Committee may affirm, modify or reverse its initial decision. Humana will notify the applicant, in writing, of the Credentials Committee's reconsideration decision within 60 days.

Reconsideration denials are final unless the decision is based on Quality criteria and the provider has the right to request a fair hearing. Practitioners who have been denied are eligible for reapply for network participation once they meet the minimum health plan's credentialing criteria.

Applying providers do not have appeal rights. However, they may submit additional documents to the address above for reconsideration by the credentialing committee.

Home health services and electronic visit verification (EVV) systems

In compliance with the 21PstP Century CURES Act, providers are required to utilize EVV to electronically monitor, track and confirm services provided in the home setting.

ARNP and PA services

Humana Healthy Horizons in Florida provides services rendered by ARNP and PA. Services may be rendered in the physician's practitioner's office, the patient's home, a hospital, a nursing facility or other approved place of service as necessary to treat a particular injury, illness or disease.

ARNPs are licensed and work in collaboration with practitioners pursuant to Chapter 464, F.S., according to protocol, to provide diagnostic and interventional patient care.

PAs are certified to provide diagnostic and therapeutic patient care and be fully licensed as a PA as defined in Chapter 458 or 459. F.S. The services must be provided in collaboration with a practitioner licensed pursuant to Chapter 458 or 459, Florida Statutes.

Humana Healthy Horizons in Florida complies with provisions of the Medicaid Physician Practitioner Services Coverage and Limitations Handbook. In no instance may the limitations or exclusions imposed by the managed care plan be more stringent than those in the Medicaid Physician Practitioner Services Coverage and Limitations Handbook.

In accordance with Section 1932(b)(7) of the Social Security Act (as enabled by Section 4704(a) of the 1997 Balanced Budget Act), the plan shall provide adequate assurances that it has the capacity to serve the expected Medicaid enrollment in that service area.

Total patient load for an FTE PCP cannot be greater than 3,000 active patients for all health care entities and lines of business.

A full-time PCP in the Humana Medical Plan may not have more than 2,400 Commercial and Medicare Member Equivalent (CMME) members enrolled in his/her panel. A Medicare member is equivalent to three non-Medicare members (ratio@1:3). A physician extender may increase the panel enrollment by an additional 1,200 CMME members.

The minimum standards for PCPs must be met to ensure adequate accessibility to all primary care services for all enrolled recipients at all ages. One FTE PCPs per 1,500 HMO Medicaid members. The ratio may be increased by 750 HMO Medicaid members for every one physician extender (ARNP or PA).

Pharmacy

Medicaid preferred drug list (PDL)

The Humana Healthy Horizons in Florida Medicaid PDL uses the same formulary as the AHCA and, as such, also has the same prior authorization requirements, step therapy requirements and dispensing limits. Since the Humana Healthy Horizons in Florida PDL is a closed formulary, some drugs are non-preferred. Please consider the alternative drugs available for your Humana Healthy Horizons-covered patients.

Providers can request an exception to the four restricted categories: not normally covered, step therapy medicines, medicines with prior authorization or medicines needing a quantity over the limits in place, by calling Humana Pharmacy Clinical Review (HCPR) at 800-555-CLIN **(800-555-2546)** or by fax at **877-486-2621**. The call center is available 8 a.m. to 6 p.m., Eastern time, Monday through Friday. Please have patient demographic and medical information ready to answer questions. You can also obtain forms and information at **Humana.com/PA**.

For select medications delivered/administered in physician's office, clinic, outpatient or home setting (fee- for-service providers only), you may contact us at:

- **Humana.com/MedPA**
- **866-461-7273** (8 a.m. – 6 p.m., Eastern time, Monday – Friday)

Pharmacy network

If newly enrolled patients are using a pharmacy not in our network, Humana Healthy Horizons in Florida will continue to allow the prescriptions to process for 60 days during the continuity-of-care period. Prior to the end of the continuity of care 60-day timeframe, Humana Healthy Horizons in Florida and its providers will educate its members on how to access their drug benefit through Humana Healthy Horizons in Florida's participating pharmacy provider network.

Humana Healthy Horizons in Florida has an over-the- counter (OTC) program through PrescribeIT (1-800-526-1490). The benefit gives up to a $25 maximum benefit coverage amount per household per month for over-the- counter items. Orders will be shipped to the member's home by UPS Inc. or the U.S. Postal Service. There is no charge for shipping. Please allow 10 to 14 working days from when the order is received.

Counterfeit-proof pads

Any Medicaid-participating prescribers or prescribers who write prescriptions for Medicaid recipients are required to use the counterfeit-proof pad.

Humana Healthy Horizons in Florida Healthy Behaviors program

Healthy Behaviors are programs offered by Humana Healthy Horizons in Florida that encourage and reward behaviors designed to improve the member's overall health. Programs administered by Humana must comply with all applicable laws, including fraud and abuse laws that fall within the purview of the U.S. Department of Health and Human Services, Office of Inspector General (OIG).

Go365 for Humana Healthy Horizons

Go365 for Humana Healthy Horizons is a wellness and rewards program that encourages members to take steps to improve their health. Members can download the Go365 for Humana Healthy Horizons app from iTunes/ Apple Shop or Google Play on a mobile device to engage in eligible healthy activities, track progress and redeem rewards. Go365 for Humana Healthy Horizons is available to members.

Eligible activities include:

- Health Risk Assessment (HRA)
- HumanaBeginnings®
- Adult well visit
- Well-child visit
- Tobacco cessation
- Weight management
- Substance abuse
- COVID-19 Vaccine
- Mammogram screening
- Cervical cancer screening
- Colorectal cancer screening To earn rewards, members must:
- Download the Go365 for Humana Healthy Horizons App from iTunes/Apple Shop or Google Play on a mobile device
- Create an account to access and engage in the program
    - Members who are 18 and older can register to create a Go365 account with their Medicaid Member ID.
    - Members younger than 18 must have a parent or guardian register on their behalf to participate and engage with the program. The person completing the registration process on behalf of a minor must have the minor's Medicaid Member ID.

If members have a MyHumana account, they can use the same login information to access Go365 for Humana Healthy Horizons, after they download the app.

For each eligible Go365 activity completed, members can earn rewards and then redeem the rewards for e-gift cards in the Go365® in-app mall. Rewards earned through Go365® have no cash value and must be earned and redeemed prior to the reward expiration date.

Members can call Go365® at **888-225-4669 (TTY: 711)** to learn more.

- **HRA:** All members have the ability to earn up to $20 in rewards when they complete their HRA ($20 reward for completing HRAs within 90 days of enrollment; $10 reward for completing their HRAs after 90 days of enrollment). Members have several options to complete the HRA: within the Go365 mobile app; online via MyHumana, mail (complete and mail paper HRA) or phone by calling **855-351-7877 (TTY: 711)**. One reward, per member, per new enrollment
- **HumanaBeginnings program:** The plan will identify pregnant members who are 13 years and older by indicators on the 834-enrollment file from the agency. Members also may self-refer by calling **800-322-2758 (TTY: 711)** ext. 1500290 or be referred by providers. Members can earn up to $50 in rewards:
    - $20 to enroll and complete HumanaBeginnings program
    - Prenatal component AND/OR
    - Postpartum component
    - $15 in rewards for members who complete (1) prenatal visit with an OB-GYN during first trimester or within 42 days of enrollment with the Plan*
    - $15 in rewards for members who complete (1) postpartum visit with an OB-GYN between 7 – 84 days after

delivery*
    - One reward, per member, per year, upon receipt of claim

*Note: members do not have to enroll and complete the HumanaBeginnings program to earn rewards for prenatal and/or postpartum visits with their OB-GYN

- **Weight management:** The weight management program is a six-month* program that delivers weight management intervention for members who are 12 years of age or older and would like to achieve or maintain a healthy weight. Eligible members who enroll and participate in the weight management program have the ability to earn up to $30 in rewards. The program offers telephonic coaching to members. Members can self-enroll into the program by calling **855-330-8053 (TTY: 711)** or be referred by a PCP.

Requires completed and signed medical clearance form from PCP to enroll in the program

- Tobacco cessation: The Tobacco Cessation program is a 7-month program* that is designed to address the needs of members who are 12 years and older who smoke or vape. The program offers telephonic coaching sessions and complimentary Nicotine Replacement Therapy (NRT), like patches, gum, and lozenges. Members can be identified for inclusion in the program through various avenues: Member or caregiver/guardian self-referral, Treating practitioner, PCP or specialist; Referral from health services case manager, disease manager, medical director or other health services professional. Referral into the program can be completed by telephone by calling 855-330-8053 (TTY: 711)
- Substance Abuse: The Substance Abuse Program is a six- month* program that offers members 18 years or older an incentive to become and remain drug-free and/ or alcohol-free. Members must work with the Substance Abuse Counselor (SAC) and must complete a minimum of six coaching sessions and outpatient treatment with the efforts of becoming and remaining drug-free and/or alcohol-free. Members can earn up to $50 in rewards.

Members have a choice of participating in one or both of these programs:

Telephonic coaching sessions

- $15 in rewards to enroll in program and complete three coaching sessions within three months of the first coaching session with a SAC
- $15 in rewards when they complete an additional three (3) coaching sessions within six months* with a SAC – a total of six sessions

Outpatient program

- $20 reward when they actively participate in one Outpatient Program for 28-30 days. To enroll: You or your patient can call **800-229-9880**
- **Adult well visit program** is designed to encourage and reward members who are 18 years and older to visit their PCP for an annual wellness visit so they can perform a thorough screening, examination and assessing of medical needs. Members will earn $20 in rewards.
- **COVID-19 vaccine program** is designed to encourage and reward eligible members who are 5 years and older to get their COVID-19 vaccine. Eligible members can earn $20 in rewards when they get their complete COVID-19 vaccine. Members must upload a copy of completed vaccine card to their Go365 account within 90 days of getting the vaccine.

Members 5 years and older

- Receive your complete COVID-19 vaccine (second dose for those that require two, or single dose for Johnson & Johnson)

Members younger than 5 years old

The number of COVID-19 vaccine doses for children younger than 5 need depends on the type of vaccine the child receives.

- Pfizer vaccine: 3-dose regimen, with the first two doses given 3 weeks apart and the last dose given at least 2 months later
- Moderna vaccine: 2-dose regimen given about 4 weeks apart

According to the FDA, caregivers should feel comfortable getting either the Pfizer or Moderna vaccine for a child.

- **Well-child visit** is designed to encourage the parent/ guardian of members 0 to 17 years of age and missed a wellness visit, based on the American Academy of Pediatrics Periodicity Schedule, to have the member see their PCP for an

annual check- up, preventive screening and necessary immunizations. Member can earn $20 in rewards, once a year.

- The **mammogram screening program** provides a reward to members who are 40 years and older to have an annual mammogram screening. In addition, members who are under 40 years old and are high- risk are encouraged to have an annual mammogram screening and will be rewarded as well. This program is designed to increase compliance and identify potential risk. Provider written order (referral) may be required for mammogram screening. Members are encouraged to check with their PCP or OB-GYN. Members can earn $20 in rewards, once per year.
- **Cervical cancer screening program** provides a reward to members who are 21 years and older to have an annual cervical cancer screening which helps to increase compliance and early identification of cervical cancer. Members have open access for OB-GYN visits and do not require a referral from a PCP. Members can earn $20 in rewards, once per year.
- **Colorectal cancer screening** is designed to encourage members 45 years and older to get an annual colorectal cancer screening. Provider written order (referral) may be required for colorectal cancer screening. Check with your PCP. Members can earn $20 in rewards, once per year.

If members don't have a mobile phone, they can call Safelink at 877-631-2550 or visit the **Safelink website** to apply for a smartphone at no cost through the Federal Lifeline Program.

Rewards have no cash value. The monetary amounts listed above are reward values, not actual dollars. For some rewards, your doctor has to tell us that you completed the healthy activity. Once we get this information from your doctor, you will see in the app the option to redeem the reward. For any reward you qualify to earn during the 2022 plan year, we must get confirmation from your doctor by no later than March 15, 2023.

Go365 for Humana Healthy Horizons is available to all members who meet the requirements of the program. Rewards are not used to direct the member to select a certain provider. Rewards may take 90 to 180 days or greater to receive. Rewards are non-transferrable to other Managed Care Plans or other programs. Members will lose access to the Go365 App to the earned incentives and rewards if they voluntarily dis-enroll from the Humana Healthy Horizons or lose Medicaid eligibility for more than 180 days. At the end of plan year (Dec. 31), members with continuous enrollment will have 90 days to redeem their rewards.

Incentives and rewards cannot be used for gambling, alcohol, tobacco or drugs (except for over-the-counter prescriptions). Incentives and rewards cannot be used for gambling, alcohol, tobacco or drugs (except for over-the- counter prescriptions). Rewards may be limited to once per year, per activity.

Members can redeem their rewards for e-gift cards to popular retailers in the Go365 Mall in the mobile app.

- E-gift cards filter out purchases like tobacco, alcohol, firearms, lottery tickets, and other items not supporting a healthy lifestyle
- The e-gift card can be applied to prescriptions, prescription co-pays, and enable the purchase of thousands of health-centric items that promote a better health and wellness in the following categories:
    - Baby care,
    - allergy remedies,
    - first aid,
    - pain relievers,
    - home diagnostics,
    - oral hygiene,
    - stomach medicine,
    - nicotine replacements, and
    - eye and ear care.

Program claims codes

Program	Age group	CPT codes	ICD-10-CM diagnosis codes	HCPCS codes
Well-child	0-17 years	99381, 99382,	Z00.00, Z00.01,	**HCPCS:** G0438,

		99383,		G0439
visit codes		99384, 99385, 99391,	Z00.110, Z00.111,	**HCPCS:** G0438, G0439
		99392, 99393, 99394,	Z00.121, Z00.129,	
		99395, 99461	Z00.2, Z00.3, Z02.5,	
			Z76.1, Z76.2	

Information is current as of Aug. 20, 2018. Program descriptions and rules are subject to change. Please contact your Provider Relations Representative with questions.

Emergency and non-emergency transportation

- For emergency transportation services, call 911.
- If a member needs a ride to a healthcare appointment that is not an emergency or to a pharmacy right after a doctor's visit, the member may call ModivCare at 866-779-0565. The member must call at least 24 hours before the appointment time.

Inpatient hospital services

For members up to age 21, the plan shall provide up to 365 days of health-related inpatient care, including behavioral health each year. Prior authorization may apply.

Physical and behavioral health

- For members age 21 and older, the plan will cover up to 45 days of inpatient coverage (extra days are covered for emergencies).
- Prior authorization and other limits may apply.

Transplant services

- The plan will cover medically necessary transplants and related services.
- Prior authorization and other limits may apply.

Minority recruitment and retention plan

Humana makes every effort to recruit and retain providers of all ethnicities to support the cultural preferences of its members. Humana's provider networks are open to review new provider participation barring provider willingness to accept contractual requirements, contractual rates and satisfy all credentialing and regulatory requirements. Humana reviews and accommodates all provider nomination requests, when appropriate, from both members and providers to ensure all providers are equally represented in Humana's provider network.

As part of this process, Humana collects and publishes spoken languages in our provider directories on Physician Finder. Please be sure to accurately indicate all languages spoken in your office(s) on your Humana recredentialing application and/or CAQH application or contact your Provider Relations Representative to have updates made.

Native Americans

Humana does not impose enrollment fees, premiums or similar charges on Native Americans served by a Native American Healthcare provider; Native American Health Service, a Native American Tribe, Tribal Organization or Urban Indian Organization; or through referral under contract health services, in accordance with the American Recovery and Reinvestment Act of 2009.

Service-level agreements

Humana's contract with AHCA includes required service-level agreements. Humana works with its network healthcare providers to achieve the following commitments:

Network adequacy

- Varying by region, 85% to 90% of PCPs are accepting new members.
- 85% to 90% of specialists are accepting new members.
- Varying by region, 40/45/50% of PCPs offer after-hours appointments.
- No more than 5/8/10% (varies by region) of hospital admissions occur in nonparticipating facilities (excludes continuity of care and emergency room).
- No more than 8/10% (varies by region) of specialty care is provided by nonparticipating specialists.

Assistive care services (ACS)

ACS are an integrated set of 24-hour services only for eligible Medicaid members. The assistive care service is a required service in the statewide Medicaid Managed Care program under both the long-term care program and the MMA program.

Telemedicine

This rule applies to any person or entity prescribing or reviewing a request for Florida Medicaid services and to all providers of Florida Medicaid services that are enrolled in or registered with the Florida Medicaid program.

Definition of telemedicine – The practice of healthcare delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis or treatment.

Practitioners licensed within their scope of practice to perform the service.

Florida Medicaid reimburses for telemedicine services using interactive telecommunications equipment that includes, at a minimum, audio equipment permitting two-way communication between a recipient and a practitioner.

Florida Medicaid does not reimburse for:

- Chart review(s), electronic mail messages or facsimile transmissions
- Equipment required to provide telemedicine services

Florida Medicaid reimburses the practitioner who is providing the evaluation, diagnosis or treatment recommendation located at a site other than where the recipient is located.

Providers must include modifier GT on the CMS-1500 claim form, incorporated by reference in Rule 59G-4.001, F.A.C.

Physicians who will be offering and/or facilitating telemedicine services in their practices need to be aware of the following state guidelines to ensure they are informed of their responsibilities, requirements and criteria for telemedicine. Offering these services may include a review of the practice by Humana's legal designee to ensure all considerations for the practice of telemedicine have been met.

If the provider is approved by Humana to provide services through telemedicine, the protocols below must be adhered to in order to prevent fraud and abuse. Provider must implement telemedicine fraud and abuse protocols that address:

- Authentication and authorization of users;
- Authentication of the origin of the information;
- The prevention of unauthorized access to the system or information;
- System security, including the integrity of information that is collected, program integrity and system integrity; and
- Maintenance of documentation about system and information usage.

Physicians offering these services to patients with Medicaid coverage need to address the following requirements:

- Telecommunication equipment and telemedicine operations meet the technical safeguards required by 45 CFR 164.312, where applicable.
- Administration of telemedicine services comply with the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal laws pertaining to patient privacy.
- Telemedicine services provided are documented in the member's medical/case record.
- Telemedicine services are offered to the member as a choice of whether to access services through face- to-face or telemedicine encounter. This needs to be documented in the member's medical/case records.

- Telemedicine services must be performed by licensed practitioners within the scope of their practice.

Please note: Medicaid does not reimburse for the costs or fees of any of the equipment necessary to provide services through telemedicine, including telecommunication equipment and services.

Physicians are encouraged to contact their provider relations representative if they are offering, or plan to offer, these services to patients with Humana Healthy Horizons in Florida coverage.

If your practice is using telemedicine with a hearing- impaired member, please call **877-320-2233**. Many telehealth platforms do not allow for an interpreter to participate, please call the Humana Concierge Service for Accessibility to use utilize our secure Doxy portal with the member, provider and interpreter. Please remember that to use telemedicine with a disabled member, nothing can be downloaded to their phone.

Delegation or Sub-delegation functions

In the event that Humana has agreed to delegate to a provider any function or responsibility that Humana is responsible for under its contract with AHCA ("Delegation Agreement") or Humana has agreed to allow a provider to sub-delegate any function or responsibility that Humana is responsible for under its contract with AHCA to a sub- delegate that Humana agreed to delegate to a provider ("Sub-Delegation Agreement"), then both the Delegation Agreement between Humana and the provider and the Sub-D elegation Agreement between the provider and sub-delegate shall include all stated requirements of Humana's contract with AHCA as well as all applicable requirements of federal and state law and accreditation organization requirements. The Delegation Agreement shall be submitted to AHCA for approval 90 days before the proposed effective date of the Delegation Agreement In the event that a Delegation Agreement does not comply with all stated requirements of Humana's contract with AHCA as well as all applicable requirements of federal and state law and accreditation organization requirements, Humana and provider shall promptly revise the Delegation Agreement to bring it into compliance with all stated requirements of Humana's contract with AHCA as well as all applicable requirements of federal and state law and accreditation organization requirements.

In the event that a Sub-Delegation Agreement does not comply all stated requirements of Humana's contract with AHCA as well as all applicable requirements of federal and state law and accreditation organization requirements, Humana will direct provider and sub-delegate to promptly revise the Sub-Delegation Agreement to bring it into compliance with all stated requirements of Humana's contract with AHCA as well as all applicable requirements of federal and state law and accreditation organization requirements.

Humana may revoke delegation or impose other sanctions if a provider's or a sub-delegate's performance under a Delegation Agreement or Sub-Delegation Agreement, as applicable, is inadequate and/or found to be out of compliance.

Reporting Requirements

Physician agrees to prepare and submit all reports and clinical information required by Humana, as required by his/her Humana agreement, including well-child visit program reporting if applicable, and in compliance with state and federal requirements.

Release due to ethical reasons

Humana has no moral or religious objections for providing any MCO covered services; however, providers are not required to perform any treatment or procedure that is contrary to the provider's conscience, religious beliefs or ethical principles, in accordance with 45 C.F.R. 88. Humana Healthy Horizons in Florida will inform members that the provider will not cover the requested service and how to access the requested service from another provider.

Process for provider request to transfer for cause of member

Providers may submit a member transfer for cause request to Humana due to disruptive, unruly, abusive, or uncooperative member/caregiver behavior that seriously impairs provider's ability to furnish services.

Requested transfers for cause cannot be based upon:

- Member inability to pay for services
- Medical or mental health reasons

- Member refusal of treatment

NOTE: Patients have the right to participate in decisions regarding their health, including the right to refuse treatment.

This process does not apply to members who:

- Have received a mental health diagnosis
- Are dealing with adverse health status changes
- Who have diminished mental capacity
- Exhibit behavior due to member special needs
- Have attempted to exercise the plan's grievance system

Members cannot be transferred until the effective date of an approved transfer. Until then, the assigned provider is responsible for member care. Providers may not take steps to transfer the member prior to obtaining transfer for cause approval from Humana.

NOTE: Please follow these steps unless your request meets the escalated exception criteria listed below in the escalated exceptions section.

To initiate a request to transfer member for cause:

1. The provider should conduct a verbal discussion with the member/caregiver at the time of the first incident and at every subsequent incident and should outline provider behavior expectations of member/caregiver behavior during office visits and phone conversations. The provider should document each conversation in the member's record.
2. If the member/caregiver continues to be disruptive, unruly, abusive, or uncooperative after verbally provided education, the provider shall send a written communication that outlines provider expectations of member/caregiver behavior during office visits and phone conversations. The provider should document and retain a copy of the written communication in the member's record.
3. If unruly, abusive, or uncooperative member/caregiver behavior continues after receipt of the written provider communication, the provider may submit a Humana Physician Medicaid-Initiated Transfer Request form to the Provider Contracting team at **Humana_FL_ Centralized_Provider_Relations@Humana.com**

The Provider Contracting team shall review the submitted form and supporting documentation to ensure they are complete and accurate. The Provider Contracting representative shall log and submit the request to the clinical medical director for review and determination.

If the medical director approves the request to transfer, the enrollment team will contact the member/caregiver three times to assist with choosing another PCP. If outreach was unsuccessful the member will automatically be re-assigned to another PCP and sent a transfer notice. The member will then receive a new Humana Healthy Horizons in Florida ID card in the mail that includes their new primary care provider's contact information.

Once the member is transferred, the Provider Contracting team will notify the requesting provider and close out the request. Upon request, the provider must send member's medical records to the newly selected provider for the purpose of continuity of care at no charge to Humana, the member or the requesting party.

If the medical director does NOT approve the transfer for cause request, the reason for denial will be given to the Provider Contracting team. The Provider Contracting team will either notify the requesting provider and request additional details as applicable or close out the request.

Escalated exceptions

If the situation between the member/caregiver and the provider has intensified to the point of law enforcement involvement, the provider may submit an escalated exception request to the Provider Contracting team.

The request should include:

- An incident description
- Any available police reports

The Provider Contracting team will escalate the request to the clinical medical director and engagement team to immediately transfer the member to another provider. A notice will be sent informing the member of the change.

Once the member is transferred, the Provider Contracting team will notify the requesting provider and close out the request. The member will receive a new Humana Healthy Horizons in Florida ID card in the mail that includes the new provider's contact information.

Florida HIE

The Office of Health Information Exchange and Policy Analysis produces statutorily mandated reports, administers the Medicaid Electronic Health Record (EHR) Incentive program, provides governance of the Florida HIE and provides research as well as analytic support to the AHCA.

- The Florida Health Information Network website, **fhin.net**, provides information and resources relating to AHCA's initiatives for Health Information Technology (HIT) and HIE.
- Details about services, as well as the latest news and events relating to the Florida HIE initiative and information on becoming a participant, can be found at: **florida-hie.net**.
- Information about the Medicaid Electronic Health Record Incentive program can be found at **ahca.myflorida.com**. Search "Electronic Health Record (EHR)."
- Reports produced by this office can be found on the research studies and reports page at **https://quality.healthfinder.fl.gov/Researchers/Studies-Reports**.

Early notification system (HIE ENS)

Florida's AHCA has collaborated with hospitals throughout Florida to provide real-time notifications of all admits, discharges and transfers (ADTs). The system relies on member panels submitted by health plans. Humana will work with providers for PCP notification and member outreach, which would include:

- Providers will receive a daily report of their patients' previous-day ER encounters, admissions and discharges.
- Humana will continue to reach out to high-utilizing members to close gaps and engage in case management.
- Physicians are encouraged to focus on reaching out and closing gaps with low-utilizing patients.

Humana recommends that providers continue the following effective strategy of notification and education to patients:

- Immediate outreach to the patient and facilitation of PCP follow-up within three days of an ER visit;
- Education regarding the right place of treatment;
- Identification and addressing of barriers to care to foster PCP/patient relationship; and
- Referrals to other internal programs (e.g., case management and social work).

Humana recommends that physicians continue the following effective strategy of notification and education to PCPs:

- Immediate notification of patient's ER visit, including chief complaint
- PCP follow-up appointment scheduled within three days of member's ER visit

Preauthorization and notification procedures

Providers must determine whether preauthorization or notification is required with respect to medical services rendered to any Humana Healthy Horizons in Florida members. To make this determination, providers must review Humana Healthy Horizons in Florida's preauthorization and notification lists, which detail medical services that require prior authorization (available on **Humana.com/PAL** in the Provider Tools and Resources section, or call Customer Service for assistance in locating the lists). (Please note: Precertification, preadmission, preauthorization and notification requirements all refer to the same process of preauthorization.)

Humana will update the lists periodically and notify providers of revisions, in accordance with the time frame specified in the provider agreement. In addition to **Humana.com/PAL** preauthorization or notification requirements for a service may be obtained by contacting Humana Healthy Horizons in Florida Customer Service.

How to obtain a preauthorization or send notification: Participating providers can obtain preauthorization and send notifications through a variety of channels through Humana's portals — **Humana.com/PAL** or **Availity.com** — or by calling

Humana Healthy Horizons in Florida clinical intake at **800-523-0023**.

CMS mandate requires the NPI is included for authorizations. As a result, NPI will be required on authorizations submitted to Humana starting 12/9/2023. This applies to authorizations submissions and inquiries (278) for all providers (requesting/referring provider, rendering/treating provider, rendering/treating facility) and lines of business, except ***atypical providers.** Any submission without an NPI will be returned for resubmission.

For hospital admission, the provider must access Availity Essentials. com or call the number listed on the back of the member's ID card. The following information is required for each hospital admission:

- Patient's name
- Patient's ID number, name and date of birth
- Date of actual or proposed admission
- Date of proposed procedure
- Bed type: inpatient or outpatient
- NPI of treatment facility or hospital
- Applicable ICD diagnosis code
- Caller's telephone number
- Attending physician's telephone number

For urgent preauthorizations or notifications, call clinical intake (available 24 hours a day) at **800-523-0023**.

Representatives are also available 8 a.m. to 8 p.m., Eastern time, Monday through Friday (excluding major holidays). Press "0" or say "representative" for live help. Have you NPI available.

In addition, Humana Healthy Horizons in Florida shall review and make a determination on all requests for preauthorization of any medically necessary service to members younger than 21 when the service is not listed in the service-specific Florida Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy or the associated Florida Medicaid fee schedule, or is not a covered service of the plan; or the amount, frequency or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

The reconsideration process is defined as the process Humana follows to review additional clinical documentation from providers to determine if a denial or partial denial should be overturned and approved, based on medical necessity criteria.

If the service requested is denied or partially denied, providers may request reconsideration of the denial determination. Providers who request reconsideration must submit additional information to Humana (via phone, fax, web, etc.,) within 10 business days of the date of the denial or partial denial determination to facilitate the reconsideration process.

Humana will review all new clinical information received for reconsideration requests and render a decision based on the new documentation. If the reconsideration is received with no new clinical information or beyond the 10 business-day submission requirement, the original decision will stand. The member or member's authorized representative may choose to file an appeal through Grievance and Appeals (G&A) (see Formal Grievances and Appeals section).

Medical records requirements

Annual medical record documentation review

The purpose of the medical record documentation review (MRDR) is to ensure Humana Healthy Horizons' compliance with maintenance of a member record for each member in accordance with the agency contract FP059, 42 CFR 431 and 42 CFR 456. Member records will include documents related to the quality, quantity, appropriateness and timeliness of services performed under this contract.

For each Medicaid recipient, the provider should maintain detailed and legible medical records that include the following:

- **Member identification:** Each page in the medical record must contain identifying information, including name, member identification number, date of birth, gender, and parent or legal guardianship (if applicable).
- **Provider identification:** The author must be identified for all entries (including dictation) and authenticate each entry as complete and accurate. Authentication may include signatures or initials.

- **Date of service/entry date:** All entries must be signed and dated within two business days of the date and time of service, or otherwise authenticated by signature, written initials, computer entry or electronic signature. Rubber stamped signatures are initialed.
- **Legibility:** The medical record must be legible to someone other than the writer.
- **Problem list:** Significant illnesses and medical conditions are indicated on the problem list.
- **Allergies:** The presence or absence of allergies (no known allergies, or NKA) must be documented in a uniform location on the medical record. Medication allergies and other adverse reactions must be listed if present.
- **Past medical history:** For members seen three or more times, past medical history should be easily identifiable and include details regarding serious accidents, operations, illnesses and familial/hereditary diseases, and a summary of significant surgical procedures, past and current diagnoses or problems, allergies, adverse reactions to drugs, and current medications.
- **Physical exam (complete):** All body systems should be reviewed within two years of the first clinical encounter, including HEENT (head, eyes, ears, nose and throat), teeth, neck, heart, lungs, and neurological and musculoskeletal systems. Height, weight, blood pressure and temperature must be documented on the initial visit.
- **History and physical:** Subjective and objective information regarding presenting complaints should be obtained and noted.
- **Working diagnosis:** The working diagnosis should be consistent with findings (i.e., the provider's medical impression.)
- **Plan/treatment:** Documentation of plan of action and treatment should be consistent with diagnoses and include all prescribed or provided services, medications, and supplies. Such services must include, but are not necessarily limited to, family-planning services, preventive services and services for the treatment of sexually transmitted diseases. In addition, all entries must include the disposition, recommendations, member instructions, evidence of any follow-up and outcome of services.
- **Records (e.g., consultation, discharge summaries and emergency room reports):** Reports should be filed in the medical record and initialed by the PCP to signify review. Past medical records and hospital records (i.e., operative and pathology reports, admission and discharge summaries, consultations and emergency room reports) should be filed in the medical record.
- **Referrals (e.g., consultation, therapy):** Referrals should be filed in the medical record.
- **X-ray, lab imaging results:** Records should show documentation of lab, X-ray, imaging or other ordered studies. Results should be filed in the medical record and initialed by the PCP to signify review. Abnormal X-ray, lab and imaging study results should have an explicit notation in the medical record regarding follow-up plans and member notification of all results (positive and negative).
- **Smoking/tobacco use:** For members seen three or more times, a notation concerning cigarette use must be present.
- **Alcohol use:** For members seen three or more times, a notation concerning alcohol use must be present.
- **Substance use:** For members seen three or more times, a notation concerning substance use must be present.
- **Immunization record:** A current record of immunizations should appear in the member chart.
- **Advance directives:** For members 21 and older, records should contain evidence members have been asked if they have an advance directive (written directions about healthcare decisions), with a yes or no response documented. If the response is yes, a copy of the advance directive must be included in the medical record and should indicate that neither the managed care plan nor any of its providers shall, as a condition of treatment, require the member to execute or waive an advance directive.
- **Prescribed medication:** All current medications, including dose and date of initial prescription or refills, should be present in the medical record and include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child younger than 13.
- **Primary language:** Use of the member's primary language should be documented, along with any communication assistance provided.
- **Florida Medicaid OB-GYN providers:** Healthy Start records should include a copy of the completed screening instrument and documentation a copy was provided to the member. Records should include documentation of preterm delivery risk assessments by the 28th week of pregnancy.

Humana and providers shall be responsible for coordination of care for new members transitioning to Humana Healthy Horizons in Florida or another plan or delivery system and shall assist with obtaining the member's medical/case records. This should be done within 30 days.

Confidentiality of medical records

For each medical record, the provider shall have a policy to ensure the confidentiality of medical records, including confidentiality of a minor's consultation, examination and treatment for a sexually transmissible disease.

The member or authorized representative shall sign and date a release form before any clinical/medical case records can be released to another party. Clinical/medical case record release shall occur in a manner consistent with state and federal law.

Providers will ensure compliance with the privacy and security provisions of HIPAA and 42 CFR, Part 431, Subpart F.

Humana and provider agree to maintain the confidentiality of information contained in the records of the provider regarding healthcare services rendered to members as required by state or federal law, rule, or regulation, including without limitation 42 CFR, Part 431, Subpart F, 42 CFR § 438.224, and HIPAA privacy and security requirements in 45 CFR Parts 160 and 164.

Right to review records

Authorized state and federal agencies and their authorized representatives may audit or examine provider records.

This examination includes all records these agencies find necessary to determine whether Florida Medicaid payment amounts were or are due. This requirement applies to the provider's records and records for which the provider is the custodian. Providers must give authorized state and federal agencies and their authorized representatives access to all Florida Medicaid recipient records and any other information that cannot be separated from Florida Medicaid-related records.

Providers must send, at their expense, legible copies of all Florida Medicaid-related information to authorized state and federal agencies or their authorized representatives upon request.

All records must be provided regardless of the media format on which the original records are retained by the provider at the time of the request. All medical records may be reproduced electronically or onto paper copies as authorized by the requestor.

Providers shall maintain complete and accurate fiscal, medical, social and other administrative records for medical services rendered to Medicaid managed care plan members and as are necessary to document the quality, appropriateness and timeliness of services performed under this agreement and in compliance with applicable state and federal laws, rules and regulations and the AHCA contract. Such records shall specifically include pertinent books, financial records, medical/case records and records of financial transactions.

Provider agrees to maintain and retain said records for a period of 10 years after Humana's contract with AHCA is terminated and/or if the records are under review or audit. **Subcontractor** agrees that the right to audit exists through 10 years from the final date of the AHCA contract period, or from the completion date of any audit, whichever is later.

In addition to record retention requirements for practitioner or provider licensure, require that subcontractors are required to retain, as applicable, the following information in accordance with 42 CFR 438.3.(u): member grievance and appeal records (42 CFR 438.416); base data (42 CFR 438.5(c); MLR reports (42 CFR 438.8(k)); and data, information, and documentation (42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608, and 42 CFR 438.610), for a period not less than 10 years from the close of the contract and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by the managed care plan if the subcontract is continuous (42 CFR 438.3(h).

Claims and encounter submission protocols and standards

Paper claims should be submitted to the address listed on the back of the member's ID card or to the appropriate address listed below:

Medical claims

Humana Healthy Horizons in Florida
Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Behavioral health claims

Regions 1 and 2
Access Behavioral Health
Attn: Claims Dept. 1221 W. Lakeview Ave. Pensacola, FL 32501

Encounters

Humana Healthy Horizons in Florida
Claims Office
P.O. Box 14605
Lexington, KY 40512-4605

Behavioral health claims:

Regions 3, 4, 5, 6, 7, 8, 9, 10 and 11
Carelon Behavioral Health
P.O. Box 1870
Hicksville, NY 11802-1870

When filing an electronic claim, you will need to utilize one of the following payer IDs:

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

For claim payment inquiries or complaints, please contact Humana customer service at **800-448-6262 (800-4HUMANA)** or your provider contracting representative. Submit claim disputes to: Humana Healthy Horizons in Florida

Provider Correspondence
P.O. Box 14601
Lexington, KY 40512-4601

If a claim dispute/appeal results in an unfavorable decision and all Humana Healthy Horizons in Florida provider dispute/appeal processes exhausted, providers may also request a review of their original appeal (at the provider's expense) by Capitol Bridge, the state's independent dispute resolution organization.

Contact information:

Capitol Bridge
Email: FLCDR@capitolbridge.com
Phone: 800-889-0549

If there is a factual disagreement with a response, send an email with the reference number to **FLMedicaidResolution@humana.com.** For information regarding electronic claim submission, contact your local provider contracting representative or visit **Humana.com/Providers** and choose "Claims and payments" then "Claims and encounter submission" or visit **Availity.com**.

In addition to the claim payment provisions outlined in the Medicaid addendum to your provider agreement, Humana should reimburse providers for Medicare deductibles and coinsurance payments for Medicare dual-eligible members according to the lesser of the following:

- Rate negotiated with the provider
- Reimbursement amount as stipulated in Section 409.908 F.S.

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

Availity Essentials™	**availity.com**	**800-282-4548**
WayStar	**waystar.com**	**877-494-7633**
TriZetto	**trizetto.com**	**800-556-2231**

McKesson	**mckesson.com**	**800-868-1309**
Change Healthcare	**capario.com**	**800-792-5256**
SSI Group	**thessigroup.com**	**800-881-2739**

AHCA requires 100% encounter submissions:

- 95% must pass through state system
- Appropriate provider registration and documentation is necessary
- Fee-for-service and capitated providers are included

Encounters and claims identify members who have received services and:

- Decrease the need for medical record review during HEDIS
- Will be critical for future world of Medicaid Risk Adjustment
- Help identify members receiving preventive screenings; decrease members appearing in reports

Sanctions for non-compliance can include liquidated damages and enrollment freezes. Payments due as a result of covered services rendered to Medicaid members shall be made by Humana on or before 90 calendar days, or such lesser time as may be contracted for between the parties, after all properly documented invoices and/or claims, and any documentation necessary for Humana to process such claims, have been received by Humana and in accordance with the reimbursement terms and conditions of the agreement and payment rates identified in Exhibit A, which is attached hereto and incorporated by reference.

Claims payments by Humana to providers shall be 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, reimbursement amount and identification of Humana entity.

Humana shall make no payment, directly or indirectly, to a provider as an inducement to reduce or limit medically necessary services to a member. If Humana operates a physician incentive plan, it shall not provide incentives, monetary or otherwise, for the withholding of medically necessary care.

Humana shall assume full responsibility for collections in the event of third-party liability.

Common submission errors and how to avoid them

Common rejection or denial reasons:

1. Patient not found
2. Insured subscriber not found
3. Patient birthdate on the claim does not match that found in Humana database
4. Missing or incorrect information
5. Providers submitting with incorrect NPI/ZIP code/ taxonomy/address/NPI type
6. Missing provider NPI/ZIP code/taxonomy
7. Providers submitting encounters with zero-dollar values
8. Rendering provider data missing for provider organizations
9. Invalid Healthcare Common Procedure Coding System (HCPCS) code submitted
10. No authorization or referral found
11. Billing/rendering/attending NPIs not enrolled/registered for Medicaid with AHCA

How to avoid these errors:

1. Confirm that patient information received and submitted is accurate and correct.
2. Ensure that all required claim form fields are complete and accurate.

3. Obtain proper authorizations and/or referrals for services rendered. Ensure you have a valid Medicaid ID for the billing/rendering/attending NPIs and taxonomies submitted on claims exactly matching the applicable active PML record.
4. Ensure billed amounts are not zero dollar. Must submit billed charges.

Submission of clean claims

A clean claim is one that does not contain a defect or requires the carrier to investigate or develop prior to adjudication and can be processed without obtaining additional information from the provider. The provider submits a clean claim by providing the required data elements on the standard claims forms along with any attachments and additional information. Claims for inpatient and facility claims are to be submitted on the UB- 04 and individual professional claims are to be submitted on the CMS-1500. Clean claims must be filed within the specified contractual time frame.

Clean claim examples

Per CMS guidance, examples of clean claims as provided in Chapter 1 – General Billing Requirements of the Medicare Claims Processing Manual:

- Do not require external development (i.e., are investigated within the claims, medical review or payment office without the need to contact the provider, the beneficiary or other outside source) (Please note: These claims are not included in CPE scoring.);
- Claims not approved for payment by Common Working File (CWF) within seven days of the FI's original claim submittal for reasons beyond the carrier's, FI's or provider's control (e.g., CWF system/communication difficulties);
- CWF out-of-service-area (OSA) claims. These are claims where the beneficiary is not on the CWF host and CWF has to locate and identify where the beneficiary record resides;
- Claims subject to medical review but complete medical evidence is attached by the provider or forwarded simultaneously with EMC records in accordance with the carrier's or FI's instructions;
- Are developed on a post-payment basis; and
- Have all basic information necessary to adjudicate the claim, and all required supporting documentation.

Clean claim submission

The CMS developed claim forms that record the information needed to process and generate provider reimbursement. The required elements of a clean claim must be complete, legible and accurate.

The Humana Companion Guide outlines all the information for the fields that Humana requires providers to submit a clean claim. The guide can be found at: **apps.humana.com/marketing/documents.asp?file=1828697**

CMS-1500 Form requirements

Field number	Title	Description
1	Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other	Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked.
1a	Insured's ID number	Enter the insured's Humana ID number (begins with an "H") as shown on insured's ID card for the payer to which the claim is being submitted. For Medicare crossover claims, enter the Medicare Identification number in this item.
2	Patient's name	Enter the patient's full last name, first name and middle initial as it appears on the Medicaid Identification Card or other proof of eligibility. (Required)
3	Patient's birth date, sex	Enter the patient's eight-digit birth date (MM | DD | YYYY). Enter an X in the correct box to indicate gender of the patient.

Field number	Title	Description
4	Insured's name	Enter the insured's full last name, first name and middle initial. No entry required unless the recipient is covered by other insurance.
5	Patient's address (multiple fields)	Enter the patient's address. The first line is for the street address; the second line, the city and state; the third line, the ZIP code. No entry is required, but the information may be helpful to identify a recipient if the Medicaid ID number is incorrect.
6	Patient relationship to insured	Enter an X in the correct box to indicate the patient's relationship to insured when Item No. 4 is completed. No entry required.
7	Insured's address (multiple fields)	Enter the insured's address. If Item No. 4 is completed, then this field should be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code. No entry required unless the recipient is covered by other insurance.
8	Reserved for NUCC use	This field was previously used to report "Patient Status." "Patient Status" does not exist in 5010A1, so this field has been eliminated.
9	Other insured's name	If Item No. 11d is marked, complete fields 9, 9a, and 9d; otherwise, leave blank. When additional group health coverage exists, enter other insured's full last name, first name and middle initial of the member in another health plan if it is different from that shown in Item No 2.
9a	Other insured's policy or group number	Enter the policy or group number of the other insured.
9b	Reserved for NUCC use	This field was previously used to report "Other Insured's Date of Birth, Sex." "Other Insured's Date of Birth, Sex" does not exist in 5010A1, so this field has been eliminated.
9c	Reserved for NUCC use	This field was previously used to report "Employer's Name or School Name." "Employer's Name or School Name" does not exist in 5010A1, so this field has been eliminated.
10a	Is patient's condition related to:	When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item No. 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. Enter an X in any part(s) that apply and give corresponding information in Item 10a-c.
10b	Is patient's condition related to:	When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item No. 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. Enter an X in any part(s) that apply and give corresponding information in Item 10a-c.
10c	Is patient's condition related to:	When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item No. 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. Enter an X in any part(s) that apply and give corresponding information in Item 10a-c.
10d	Claim codes	When required by payers to provide the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this field. No entry is required for Medicaid only billing. For Medicare crossover claims, enter the recipient's 10-digit Medicaid ID number.

Field number	Title	Description
11	Insured's policy, group, or FECA number	Enter the insured's policy or group number as it appears on the insured's Healthcare identification card. If Item No. 4 is completed, then this field should be completed.
11a	Insured's date of birth, sex	Enter the eight-digit date of birth (MM|DD|YYYY) of the insured and an X to indicate the sex (gender) of the insured. No entry required.
11b	Other claim ID (designated by NUCC)	Enter the "Other Claim ID." No entry required.
11c	Insurance plan name or program name	Enter the name of the insurance plan or program of the insured. Some payers require an identification number of the primary insurer rather than the name in this field. No entry required.
11d	Is there another health benefit plan?	When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d. Only one box can be marked. No entry required.
12	Patient's or authorized person's signature	Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in six-digit (MM|DD|YY) or eight-digit format (MM|DD|YYYY) format. If there is no signature on file, leave blank or enter "No Signature on File." No entry required.
13	Insured's or authorized person's signature	Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File." No entry required.
14	Date of current illness, injury, or pregnancy (LMP)	Enter the six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) date of the first date of the present illness, injury or pregnancy. No entry required.
15	Other date	Enter another date related to the patient's condition or treatment. Enter the date in the six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) format. No entry required.
16	Dates patient unable to work in current occupation	If the patient is employed and is unable to work in current occupation, a six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) date must be shown for the "from – to" dates that the patient is unable to work. No entry required.
17	Name of referring provider or other source	Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. Leave blank if the procedure for which you are billing was not referred, did not require approval by a MediPass PCP or did not require service authorization.
17a	Other ID number	The Other ID number of the referring, ordering or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.
17b	NPI number	Enter the NPI number of the referring, ordering or supervising provider in Item No. 17b. Enter either qualifier code 1D and the Medicaid provider number in 17a or the NPI number in 17b. If you enter the NPI in 17b and the referring provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, in item 17a, enter qualifier code ZZ in the small field and enter the referring physician's taxonomy in the large field of 17a.

Field number	Title	Description
18	Hospitalization dates related to current services	Enter the inpatient six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization. No entry is required, but an entry is preferred.
19	Additional claim information (Designated by NUCC)	Please refer to the most current instructions from the public or private payer regarding the use of this field. No entry required.
20	Outside lab? $Charges	Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim. No entry required.
21	Diagnosis or nature of illness or injury	Enter the applicable ICD indicator to identify which version of ICD codes is being reported.
22	Resubmission and/or original reference number	List the original reference number for resubmitted claims. No entry required.
23	Prior authorization number	Enter any of the following: prior authorization number, referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service.
24a	Date(s) of service [lines 1–6]	Enter date(s) of service, both the "From" and "To" dates.
24b	Place of service [lines 1–6]	In 24b, enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed.
24c	EMG [lines 1–6]	Check with payer to determine if this information (emergency indicator) is necessary. If the service was an emergency, enter a Y for yes in the unshaded area of the field. If the service was not an emergency, leave the item blank.
24d	Procedures, services, or supplies [lines 1–6]	Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service.
24e	Diagnosis pointer [lines 1–6]	In 24e, enter the diagnosis code reference letter (pointer) as shown in Item No. 21 to relate the date of service and the procedures performed to the primary diagnosis.
24f	$ Charges [lines 1–6]	Enter the charge amount for each listed service.
24g	Days or units [lines 1–6]	Enter the number of days or units.
24h	EPSDT/Family Plan [lines 1–6]	For reporting of Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) and Family Planning services, refer to specific payer instructions. Hospice: For all recipients in hospice, enter H in the shaded area of Item 24h.
25	Federal Tax ID Number	Enter the "Federal Tax ID Number" (employer ID number or SSN) of the Billing Provider identified in Item No. 33. No entry required.
26	Patient's Account No.	Enter the patient's account number assigned by the provider of service's or supplier's accounting system. The provider may enter a recipient account number so that it will appear on the remittance advice.
27	Accept Assignment?	Enter an X in the correct box. Only one box can be marked no entry required.
28	Total Charge	Enter total charges for the services (i.e., total of all charges in 24f).

Field number	Title	Description
29	Amount Paid	Enter total amount the patient and/or other payers paid on the covered services only.
30	Reserved for NUCC Use	This field was previously used to report “Balance Due.” “Balance Due” does not exist in 5010A1, so this field has been eliminated no entry required.
31	Signature of Physician or Supplier Including Degrees or Credentials	“Signature of Physician or Supplier Including Degrees or Credential” does not exist in 5010A1.
32	Service Facility Location Information	Enter the name, address, city, state, and ZIP code of the location where the services were rendered.
32a	Service Facility Location Information	Enter the name, address, city, state and ZIP code of the location where the services were rendered no entry required.
32b	Other ID #	Enter the qualifier identifying the non-NPI number followed by the ID number no entry required.
33	Billing Provider Info & Phone #	Enter the provider’s or supplier’s billing name, address, ZIP code and phone number.
33a	Billing Provider Info & Phone #	Enter the provider’s or supplier’s billing name, address, ZIP code and phone number.
33b	Other ID #	Enter the qualifier identifying the non-NPI number followed by the ID number.

UB-04 Form instructions

Form Locator	Title	Action
1	Provider Name, Address, Telephone Number, Fax Number, and Country Code	Line 1: Provider Name Line 2: Street Address or Post Office Box Line 3: City, State and ZIP Code plus 4 Line 4: Telephone; Fax; Country Code (if other than USA)
2	Pay-To Name, Address, and ID	Report only when pay-to name and address is different than the Billing Provider in Form Locator 1.
3a	Patient Control Number	Enter patient’s unique (alphanumeric) number assigned by the provider. Any letter or number combination up to 20 digits is acceptable.
3b	Medical Record Number	Enter the number assigned to the patient’s medical or health record by the provider. This is an optional item.
4	Type of Bill	Enter the appropriate four-digit code for the type of bill from the coding table below.
5	Federal Tax Number	Upper Line: Optional federal tax sub-ID number. Lower Line: Enter as NN-NNNNNNN

Form Locator	Title	Action
6	Statement Covers Period – From/ Through	Inpatient: Enter the beginning and ending service dates for this bill in month, day, year format: MMDDYY. For admission and discharge on the same day, the From and Through dates are the same. Inpatient Psychiatric Services: Enter the beginning and ending service dates of the period included by this bill in MMDDYY format. Outpatient: Enter the date of service in MMDDYY format. Only the services received in a single day can be billed on an outpatient claim, with the exception of outpatient Medicare crossover claims. The “from” and “through” dates are the same. Freestanding Dialysis Center: Enter the beginning and ending service dates in MMDDYY format for this bill. Do not show dates before the recipient’s Medicaid eligibility began. For services received on a single day, the” from” and “through” dates must be the same. Hospice: Enter the beginning and ending service dates in MMDDYY format for this bill. Do not show dates before the recipient’s Medicaid eligibility began. For services received on a single day, the “from” and “through” dates must be the same. Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the beginning and ending service dates for the month being billed in month, day, year format: MMDDYY.
7	Unlabeled	No entry required.
8a	Patient ID	Report only if number is different from the insured’s ID in Form Locator 60.
8b	Patient Name	Enter the recipient’s last name, first name and middle initial exactly as it appears on the Medicaid identification card or other Medicaid proof of eligibility.
9	Patient Address	Subfield a: Street Address or Post Office Box Subfield b: City Subfield c: State Subfield d: ZIP Code Subfield e: Country Code (no entry required)
10	Patient Birthdate	Enter the patient’s date of birth in the MMDDYYYY format.
11	Patient Sex	Enter the letter “M” if the patient is male, “F” if the patient is female, or “U” if unknown.
12	Admission Date	Inpatient: Enter the patient’s date of admission in the MMDDYY format. Example: 042107 for April 21, 2007. Outpatient: Enter the date of service. Freestanding Dialysis Centers: No entry required. Hospice: Enter the patient’s date of admission in MMDDYY format. This date must be the same as the effective date of hospice election or change of election. Long-Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the patient’s date of admission to the facility or to a new Level of Care in MMDDYY format.
13	Admission Hour	Inpatient: Not required, but desirable. Enter the code for the hour of admission converted to 24-hour time as shown below: **CODE TIME AM CODE TIME PM**

Form Locator	Title	Action
		00 12:00-12:59 (Midnight) 12 12:00-12:59 (Noon) 01 01:00-01:59 13 01:00-01:59 02 02:00-02:59 14 02:00-02:59 03 03:00-03:59 15 03:00-03:59 04 04:00-04:59 16 04:00-04:59 05 05:00-05:59 17 05:00-05:59 06 06:00-06:59 18 06:00-06:59 07 07:00-07:59 19 07:00-07:59 08 08:00-08:59 20 08:00-08:59 09 09:00-09:59 21 09:00-09:59 10 10:00-10:59 22 10:00-10;59 11 11:00-11:59 23 11:00-11:59 Outpatient: No entry required, but desirable. Hospice, Freestanding Dialysis Centers, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry required.
14	Type of Admission or Visit	Inpatient: Enter the code indicating the priority of this admission: 1. Emergency: The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room. 2. Urgent: The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation. 3. Elective: The patient's condition permits adequate time to schedule the availability of a suitable accommodation. 4. Newborn: A baby born within this facility. Use of this code necessitates the use of special Source of Admission codes. See Form Locator 15. 5. Trauma Center: Visit to a trauma center or hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involves a trauma activation. 9. Information not available. Outpatient: Enter code 1 for emergencies; code 2 for urgent cases; or code 5 (Trauma Center) if the patient was seen in a trauma center or hospital. Otherwise, no entry is required. MediPass authorization is not required if the type of admission is 1 or 5. Hospice, Freestanding Dialysis Centers and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry required.
15	Source of Referral for Admission or Visit	Inpatient, Hospice, and Freestanding Dialysis Centers: Enter the code indicating the source of the referral for this admission or visit. Newborn coding must be used when the Type of Admission Code in Form Locator 14 is 4. See next page for newborn codes.
16	Discharge Hour	Inpatient: Enter the hour of discharge from the hospital, converted to 24-hour time as shown in the coding table for Form Locator 13. Outpatient: No entry required, but desirable. Freestanding Dialysis Centers: No entry required. Hospice: No entry required. Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry required.

Form Locator	Title	Action
17	Patient Discharge Status	Inpatient, Outpatient and Hospice: Enter the code indicating patient status as of the discharge date or last date billed in the case of interim billing as reported in Form Locator 6–Statement Covers Period.
18	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
19	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
20	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
21	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
22	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
23	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
24	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
25	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
26	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.

Form Locator	Title	Action
27	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
28	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
29	Accident State	When medical services resulted from an auto accident, enter the state code for the state in which the accident occurred, i.e., FL, GA, etc.
30	Unlabeled	No entry required.
31	Occurrence Code and Date	Inpatient and Outpatient: Enter the code and associated date defining a significant event relating to this bill. If only one code and date are used, they must be entered in Form Locator 31a. If more than one code and date are used, they must be entered in Form Locators 31a through 34a, then 31b through 34b, in alphanumeric sequence. Enter the date in MMDDYY format. If all of the Occurrence Code fields are filled, use available occurrence span code fields (35-36).
32	Occurrence Code and Date	Inpatient and Outpatient: Enter the code and associated date defining a significant event relating to this bill. If only one code and date are used, they must be entered in Form Locator 31a. If more than one code and date are used, they must be entered in Form Locators 31a through 34a, then 31b through 34b, in alphanumeric sequence. Enter the date in MMDDYY format. If all of the Occurrence Code fields are filled, use available occurrence span code fields (35-36).
33	Occurrence Code and Date	Inpatient and Outpatient: Enter the code and associated date defining a significant event relating to this bill. If only one code and date are used, they must be entered in Form Locator 31a. If more than one code and date are used, they must be entered in Form Locators 31a through 34a, then 31b through 34b, in alphanumeric sequence. Enter the date in MMDDYY format. If all of the Occurrence Code fields are filled, use available occurrence span code fields (35-36).
34	Occurrence Code and Date	Inpatient and Outpatient: Enter the code and associated date defining a significant event relating to this bill. If only one code and date are used, they must be entered in Form Locator 31a. If more than one code and date are used, they must be entered in Form Locators 31a through 34a, then 31b through 34b, in alphanumeric sequence. Enter the date in MMDDYY format. If all of the Occurrence Code fields are filled, use available occurrence span code fields (35-36).
35	Occurrence Span Code and Dates	If Condition Code C3 was entered in Form Locators 18-28, enter the Occurrence Code M0 and the first and last days that were approved when not all of the stay was approved.
35a	Occurrence Span Code and Dates	If Condition Code C3 was entered in Form Locators 18-28, enter the Occurrence Code M0 and the first and last days that were approved when not all of the stay was approved.

Form Locator	Title	Action
36	Occurrence Span Code and Dates	If Condition Code C3 was entered in Form Locators 18-28, enter the Occurrence Code M0 and the first and last days that were approved when not all of the stay was approved.
37	Unlabeled	No entry required.
38	Responsible Party Name and Address	No entry required.
39a-d	Value Codes and Amounts	Inpatient and Outpatient: Required for Medicare and Medicaid crossovers only if one or more of the codes below is applicable. Hospice: Enter the value code and amount if applicable. 31 Patient Responsibility: Enter value code 31 and the amount of patient liability, even if the amount is $0. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days. Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the value code and amount. 31 Patient Responsibility: If the patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days. Medicaid reimburses the date of admission, but not the date of discharge, so that day is not included in the total number of days. If the recipient is admitted and discharged on the same day, the system will count it as one day. The DCF staff calculates the patient responsibility and notifies the nursing facility in writing of the correct amount of patient responsibility. The facility must receive this notice before it submits its first claim for payment. When DCF notifies a facility of a change in the amount of patient responsibility for a past month, the facility must submit an adjusted claim. For Medicare crossover claims (level of care X), enter the patient responsibility amount unless the recipient is a QMB only or a QMB+. There is no patient responsibility for QMB and QMB+ nursing facility residents during the Medicare coinsurance period. 80 Covered Days: The number of days covered by the primary payer as qualified by the payer.
40a-d	Value Codes and Amounts	Inpatient and Outpatient: Required for Medicare and Medicaid crossovers only if one or more of the codes below is applicable. Hospice: Enter the value code and amount if applicable. 31 Patient Responsibility: Enter value code 31 and the amount of patient liability, even if $0. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days. Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the value code and amount. 31 Patient Responsibility: If the patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days. Medicaid reimburses the date of admission, but not the date of discharge, so that day is not included in the total number of days. If the recipient

Form Locator	Title	Action
		is admitted and discharged on the same day, the system will count it as one day. The Department of Children and Families (DCF) staff calculates the patient responsibility and notifies the nursing facility in writing of the correct amount of patient responsibility. The facility must receive this notice before it submits its first claim for payment. When DCF notifies a facility of a change in the amount of patient responsibility for a past month, the facility must submit an adjusted claim. For Medicare crossover claims (level of care X), enter the patient responsibility amount unless the recipient is a QMB only or a QMB+. There is no patient responsibility for QMB and QMB+ nursing facility residents during the Medicare coinsurance period. 80 Covered Days: The number of days covered by the primary payer as qualified by the payer.
41a-d	Value Codes and Amounts	Inpatient and Outpatient: Required for Medicare and Medicaid crossovers only if one or more of the codes below is applicable. Hospice: Enter the value code and amount if applicable. 31 Patient Responsibility: Enter value code 31 and the amount of patient liability, even if $0. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days. Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the value code and amount. 31 Patient Responsibility: If the patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days. Medicaid reimburses the date of admission, but not the date of discharge, so that day is not included in the total number of days. If the recipient is admitted and discharged on the same day, the system will count it as one day. The Department of Children and Families (DCF) staff calculates the patient responsibility and notifies the nursing facility in writing of the correct amount of patient responsibility. The facility must receive this notice before it submits its first claim for payment. When DCF notifies a facility of a change in the amount of patient responsibility for a past month, the facility must submit an adjusted claim. For Medicare crossover claims (level of care X), enter the patient responsibility amount unless the recipient is a QMB only or a QMB+. There is no patient responsibility for QMB and QMB+ nursing facility residents during the Medicare coinsurance period. 80 Covered Days: The number of days covered by the primary payer as qualified by the payer.
42	Revenue Code	Enter the appropriate four-digit revenue codes itemizing accommodations, services, and items furnished to the patient in your facility. Freestanding Dialysis Centers: Revenue center codes 0821 and 0831 represent covered services. Revenue Codes 0821 and 0831 may be billed only once on the claim. Enter the number of units in Form Locator 46. Chapter 3 of the Florida Medicaid Freestanding Dialysis Center Services Coverage and Limitations Handbook lists the drugs that are billed with revenue center codes 0634, 0635, and 0636. When billing for a drug, enter

Form Locator	Title	Action
		the corresponding five-digit HCPCS procedure code in Form Locator 44. Use revenue code 0636 when dispensing AHCA-specified charges for drugs and biologics that are billed under revenue code 0636 (with the exception of radiopharmaceuticals, which are reported under Revenue Codes 0343 and 0344) require specific identification. If using a HCPCS to describe the drug, enter the corresponding five-digit HCPCS procedure code in Form Locator 44. Enter the specific service units reported in hundreds (100s); rounded to the nearest hundred; do not use a decimal.
43	Revenue Code Description	Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter a written description of the related revenue categories included on this bill. Line 23: Page of - On multiple page claims, all required fields must be completed on each page of the claim. Enter the page number and the total number of pages on the bottom of each claim page. For example, the first page would be numbered page 1 of 2, the second page, page 2 of 2. Outpatient: Florida Medicaid is collecting NDC information on Centers for Medicare and Medicaid Services designated, physician administered drugs in the outpatient hospital setting. The NDC is required on claims for drugs, including Medicare-Medicaid crossover claims for drugs. See the instructions below for entering the NDC. Freestanding Dialysis Centers: The NDC is required on claims for drugs, including Medicare-Medicaid crossover claims for drugs. See the instructions below for entering the NDC. Florida Medicaid will reimburse freestanding dialysis centers only for drugs for which the manufacturer has a federal rebate agreement per SEC. 1927. [42 U.S.C. 1396r-8]. The current list of manufacturers who have drug rebate agreements is available on AHCA's website at **ahca.myflorida.com**. Click on Medicaid, scroll down to "What is Occurring in Medicaid," and then click on "Current List of Drug Rebate Manufacturers." Instructions for Entering the NDC: When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug in Form Locator 43 for the specified detail line. Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units. The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer's labeler code, the middle four digits are the product code, and the last two digits are the package size. If you are given an NDC that is less than 11 digits, add the missing digits as follows: • For a 4-4-2 digit number, add a 0 to the beginning. • For a 5-3-2 digit number, add a 0 as the sixth digit. • For a 5-4-1 digit number, add a 0 as the tenth digit. Enter the Unit Qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. The Unit Qualifiers are: • F2 – International Unit • GR – Gram • ML – Millimeter • UN – Unit
44	HCPCS/Rates/HIPPS Rate	Inpatient: Required for inpatient newborn hearing screening services.

Form Locator	Title	Action
	Codes	When revenue code 0471 is entered in Form Locator 42, enter the appropriate hearing screening CPT code that best describes the service rendered. They are 92585, 92587, 92585-TC, and 92587-TC. For details on inpatient procedure codes required with revenue codes 0360, 0361, 0722, 0750, and 0790, see the instructions for Form Locator 74. Outpatient: Enter the five-digit CPT-4 lab code from the Outpatient Hospital Laboratory Fee Schedule when billing for laboratory revenue codes (0300-0314). Do not bill radiology services with CPT codes. Radiology services performed by hospitals are billed by revenue code only. Revenue codes 0360, 0361, 0722, 0750, and 0790 require the entry of a HCPCS CPT procedure code. Revenue code 0471 requires the entry of one of the following newborn hearing screening codes in this form locator: 92585, 92587, 92588, 92585-TC, 92587-TC, or 92588-TC. Revenue code 0451 requires the entry of CPT code 99281 (emergency room screening and evaluation). Bill 0451 (99281) when the recipient had to be screened per EMTALA but required no further emergency room services. Centers for Medicare and Medicaid Services designated, physician administered drugs, for which the National Drug Code is reported, require the entry of the appropriate HCPCS code. Freestanding Dialysis Centers: Claims for the administration of Erythropoietin (Epogen, EPO) require the entry of the five-digit injection HCPCS code. When billing for drugs and biologicals, the 11-digit National Drug Code (NDC) is required in Form Locator 43 along with the five-digit HCPCS code in Form Locator 44. (See Form Locator 43 for details instructions on entering the 11-digit NDC on the claim.) Hospice: When billing revenue center code 0657, enter the corresponding five-digit CPT-4 code that is in the Florida Medicaid Hospice Coverage and Limitations Handbook. No other codes are covered. Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry is required.
45	Service Date	Required on outpatient claims. Lines 1–22: On each line, enter the date of service. Line 23: On each page, enter the date the bill was created or prepared for submission in MMDDYY format.
46	Units of Service	This form locator will accept up to seven characters. Leading zeros are not required. Inpatient: Enter the number of units of service and number of days for accommodations. A late discharge may not be billed as an additional day. Outpatient: Enter the units of service for each revenue code. Hospice: Enter the number of units of service for each type of service. Units are measured in days for codes 0651, 0655, 0656 and 0659; in hours for code 0652; and in procedures for 0657. Freestanding Dialysis Centers: Enter the units of service for the revenue center code(s). For revenue center codes 0821 and 0831, units are measured in the number of dialysis treatments the patient received in the billing period. Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the number of days associated with each revenue code. Medicaid reimburses the date of admission, but not the date of discharge. Include the date of

Form Locator	Title	Action
		admission, but do not include the date of discharge in the total number of days. If the recipient is admitted and discharged on the same day, count it as one day.
47	Total Charges	Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers: Enter the total charge for each revenue code or procedure code entry. This entry must be the sum of the individual charges. Line 23: Enter the total of all revenue code charges on the final page of the claim, along with revenue code 0001. Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the total charge for each revenue code or procedure code entry. This entry must be the sum of the individual charges. Do not deduct the patient responsibility. Line 23: Enter the total of all revenue code charges on the final page of the claim, along with revenue code 0001. For Medicare crossover claims (level of care X), compute the total charge using the Medicare rate instead of the Medicaid per diem. If the Medicare rate for a recipient changed during the month, use the weighted average Medicare rate (weighted based on the number of days each rate is paid).
48	Non-covered Charges	Inpatient: No entry required. Outpatient, Hospice, and Freestanding Dialysis Centers: Enter the total payment received or expected to be received from a primary insurance payer identified in Form Locator 50A. Enter each portion of the payment applicable to each code in Form Locator 48. Enter the total amount payment received or expected to be received from a primary insurance payer on the final page of the claim in Line 23. If the primary insurance payer other than Medicare pays a lump sum payment, enter a prorated amount on each line. If there is more than one other private payer, lump all amounts together in Form Locator 48 and attach each company's Explanation of Benefits or remittance. Electronic software allows separate entries on an outpatient claim for primary, secondary, and tertiary payer payments. If billing on a paper claim and there is more than one private payer, attach documentation to show how much each payer paid for each line item. Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry is required.
49	Unlabeled	No entry required.
50A-C	Payer Name	Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter "Florida Medicaid" for the Medicaid payer identification. Enter the name of the third-party payer if applicable: • 50A – Primary Payer • 50B – Secondary Payer 50C – Tertiary Payer
51A-C	Health Plan ID	For Medicaid, leave blank. If the health plan in Form Locator 50 has a number, report the number in 51 A, B or C depending on whether the insurance is primary, secondary or tertiary.
52A-C	Release of Information	Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Indicate whether the patient or patient's legal representative has signed a

Form Locator	Title	Action
		statement permitting the provider to release data to other organizations. The Release of Information is limited to the information carried in this claim. A = Primary B = Secondary C = Tertiary Code Structure: I = Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes. (Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.) Y = Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim. (Required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.)
53A-C	Assignment of Benefits	No entry required.
54A-C	Prior Payments	Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the amount that the provider has received toward payment of this bill prior to the billing date on this claim. Do not put the Medicaid amount due in this form locator. Inpatient and Outpatient: If no payment was received or if the service was denied, attach a copy of the EOB from the insurance carrier with the reason for the denial.
55A-C	Estimated Amount Due	No entry required.
56	NPI	The National Provider Identifier (NPI) is a unique HIPAA-mandated number assigned to the provider submitting the bill. The provider may enter either its NPI number in Form Locator 56 or its Medicaid provider number in Form Locator 57. If the provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, the rendering provider must enter qualifier code B3 and the taxonomy code in Form Locator 81. Entry of the NPI on paper claims is optional. Florida Medicaid prefers that the provider continue to enter Medicaid provider numbers on paper claims.
57A-C	Other Provider ID	Use if an identification number other than NPI is being reported. The provider may enter either its NPI number in Form Locator 56 or its Medicaid provider number in Form Locator 57.
58A-C	Insured's Name	Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the insured's last name, first name, and middle initial exactly as it appears on the Medicaid ID card or other proof of eligibility. If the recipient is covered by insurance other than Medicaid, enter the name of the individual in whose name the insurance is carried.
59A-C	Patient's Relationship	Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the code indicating the relationship of the patient to the identified insured. • Line A: Primary Payer, Required

Form Locator	Title	Action
		• Line B: Secondary Payer, Situational • Line C: Tertiary Payer, Situational Code Structure: • 01 = Spouse • 18 = Self • 19 = Child 21 = Unknown
60A-C	Insured's Unique ID	Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter all of the insured's unique identification numbers assigned by any payer organizations, including Humana's Member ID, beginning with "H". The recipient's 10-digit Medicaid ID number must be verified and entered. This entry must correspond with the Medicaid payer entry in Form Locators 50 A, B, or C. If Medicaid is primary, enter the recipient's Medicaid ID number in Form Locator 60A. If Medicaid is secondary, enter the recipient's Medicaid ID number in Form Locator 60B.
61A-C	Insurance Group Name	No entry required.
62A-C	Insurance Group Name	No entry required.
63A-C	Treatment Authorization Code	Inpatient – MediPass: If a recipient younger than 21 is in the Children's Medical Services' (CMS) Network and the MediPass PCP authorized the services being billed, enter the nine-digit MediPass authorization number that was given to the hospital in Form Locator 63A. This number is different from the 10-digit prior authorization number issued by the PRO for inpatient services. If the recipient in the CMS Network is admitted due to an emergency, no MediPass authorization number is required in this form locator. This requires type of admission code 1 or 5 in Form Locator 14. A MediPass authorization number is not required for any type of inpatient admission for any other category of recipient, except for children in the CMS Network. If there is authorization from the PRO, enter the prior authorization number that covers the authorized days in Form Locator 63A, if Medicaid is the primary payer, or in Form Locator 63B, if Medicaid is the secondary payer. Most inpatient admissions require authorization from the PRO before Medicaid payment can be made. However, there are several exemptions from inpatient authorization. An exemption from authorization allows Medicaid to pay an inpatient claim without authorization from the PRO and without a prior authorization number on the claim form. Note: See Chapter 3 in this manual for information on the types of admissions and recipient categories that require inpatient authorization and the listing of recipient categories and circumstances that are exempt from authorization. Inpatient – Psychiatric or Substance Abuse: When the admitting and primary diagnosis code is in the range of 290-314.9 or 648.30-648.44, prior authorization by the psychiatric PRO is required. Enter the prior authorization number that covers this hospitalization in Form Locator 63A, if Medicaid is the primary payer, or in 63B, if Medicaid is the secondary payer. Note: See Chapter 3 in this manual for information on inpatient psychiatric

Form Locator	Title	Action
		or substance abuse authorization requirements. Outpatient: Outpatient services to recipients enrolled in MediPass require authorization from the MediPass PCP before services can be rendered, if the outpatient encounter is not an emergency. Enter the MediPass authorization number in Form Locator 63A if Medicaid is the primary payer or in 63B if Medicaid is the secondary payer. MediPass authorization is not required for true emergencies. This is indicated by the code entry of 1 or 5 for type of admission in Form Locator 14. It is also not required for Emergency Room Screening and Evaluation Services required by the Emergency Medical Treatment and Active Labor Act (EMTALA), billed using revenue code 0451 with HCPC (99281). Hospice: No entry required Freestanding Dialysis Centers: No entry required. Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry required.
64A-C	Document Control Number	No entry required. If the claim is an adjustment or void of a previously paid claim, enter the 13-digit Internal Control Number in Form Locator 80 on Line 2.
66	No entry required. If the claim is an adjustment or void of a previously paid claim, enter the 13-digit Internal Control Number in Form Locator 80 on Line 2.	Enter the qualifier that identifies the version of the International Classification of Diseases (ICD) reported: • 9 – Ninth Revision 0 – Tenth Revision
67	Principal Diagnosis	This Form Locator is optional; it is not entered in the Florida Medicaid Management Information System. Inpatient and Hospice: Enter the most specific fourth and fifth digit ICD code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization or need for hospice care) that exists at time of admission or develops subsequently that has an effect on the length of stay. Psychiatric admissions require the entry of a diagnosis in the range of 290-314.9 or 648.30-648.44 in this form locator and in Form Locator 69. A prior authorization number from the psychiatric PRO is required when the principal diagnosis is in the ranges noted here. If Medicaid is primary, the psychiatric PRO issued PA number is entered in Form Locator 63a; if Medicaid is secondary, the PA number is entered in Form Locator 63b. Outpatient: Enter only the most specific ICD code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing the use of hospital services that exists at time of service). Freestanding Dialysis Centers: Enter only the most specific ICD code describing the principal diagnosis for the condition chiefly responsible for causing the need for dialysis services. For example, diagnosis code 585.6 for end-stage renal disease. Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter only the most specific ICD code describing the principal diagnosis for the condition chiefly responsible for causing the need for long-term care.

Form Locator	Title	Action
67A-Q	Other Diagnoses	Enter diagnoses that are other than the principle diagnosis. Inpatient: Enter the most specific ICD diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or developed subsequently and had an effect on the treatment received during the length of stay. Outpatient: Enter the most specific ICD diagnosis codes that correspond to additional conditions that co-exist at the time of service. Inpatient and Outpatient: Present on Admission (POA) Indicator: The POA Indicator applies to diagnosis codes, not only on the conditions known at the time of admission, but also include those conditions that were clearly present, but not diagnosed, until after the admission took place. Present on admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, are considered as present on admission. The POA indicator is applied to the principal diagnosis as well as all secondary diagnoses that are reported. The five reporting options for all diagnosis reporting are as follows: • Y = Yes • N = No • U = No Information in the Record • W = Clinically Undetermined • (Unreported—Not Used) = Exempt from POA Reporting Hospice: No entry required. Freestanding Dialysis Centers: Enter the most specific ICD diagnosis codes that correspond to additional conditions that co-exist at the time of service. Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry required. Special Circumstances When Diagnosis Codes are NOT Required on Outpatient Claims: Diagnosis codes are not required on outpatient claims when the type of bill is 141 (hospital-referenced diagnostic services) or when either of the following: • The only revenue center codes on the claim are in the range 0300–0307. • The only revenue center codes on the claim are any one or any combination of the following (with any Type of Admission code): 0310, 0311, 0312, 0314, 0320, 0321, 0322, 0323, 0324, 0340, 0341, 0400, 0401, 0402, 0460, 0610, 0611, 0612, 0730, 0731, 0740.
68	Unlabeled	No entry required.
69	Admitting Diagnosis	Inpatient: Required for all inpatient claims and claims with Type of Bills (Form Locator 4): 011X, 012X, 018X and 021X. The presence of an admitting diagnosis in 290–314.9, or 648.30–648.44 range, psychiatric or substance abuse, indicates that the inpatient services needed authorization by the psychiatric PRO. Outpatient: Required for outpatient to report the presenting symptom (diagnosis) and the reason for the patient's visit on claims that contain emergency services. Hospice, Freestanding Dialysis, and Long-term Care Facilities (Skilled

Form Locator	Title	Action
		Nursing Facilities and ICF/DDs): No entry required.
70 a-c	Patient's Reason for Visit Code	Outpatient: Enter the diagnosis codes describing the patient's reason at the time of the outpatient registration. This is required for all unscheduled outpatient visits as defined when the following occurs: Form Locator 4, Type of Bill 013X or 085X; Form Locator 14, Type of Admission codes 1, 2, or 5; and Form Locator 42, Revenue Codes 045X, 0516, 0526 or 0762 (Observation Room). Inpatient, Hospice, Freestanding Dialysis, and Long-term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry required.
71	PPS Code	No entry required.

Timely filing

Providers are required to file timely claims/encounters for all services rendered to Medicaid members. Timely filing is an essential component of Humana's HEDIS reporting and ultimately can affect how a plan and its providers are measured in member preventive care and screening compliance.

Providers shall submit to Humana all claims, and if capitated shall submit encounter data, for medical services rendered to Medicaid managed care plan members in accordance with the terms and conditions in the AHCA contract.

Notwithstanding anything to the contrary in the agreement, provider or subcontractor agrees to submit such claims within six months from the date of service, or encounter data, as applicable, to Humana within 30 days from the date of service. First time facility claims must be received within six months from the through date to be considered timely.

The encounter data submission standards required to support encounter data collection and submission are defined by the agency in the Medicaid Companion Guides, Pharmacy Payer Specifications and this section. In addition, the agency will post encounter data reporting requirements on the following websites:

- **portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_CompanionGuides/tabId/62/Default.aspx**
- **portal.flmmis.com/FLPublic/Provider_Pharmacy/tabId/52/Default.aspx**

Claims overpayments

Provider shall report to Humana all claim overpayments for medical services rendered to Medicaid managed care plan members in accordance with the terms and conditions in the AHCA contract that have been received.

Notwithstanding anything to the contrary in the agreement, provider or subcontractor agree to submit such claims within 60 days after the date on which the overpayment was identified, and to notify Humana in writing the reason for the overpayment as required by 42 CFR 438.608(d)(2). To be mailed to:

Humana Healthcare Plans
P.O. Box 931655
Atlanta, GA 31193-1655 Payment Suspension

Humana shall pay nursing facility providers in compliance with 42 CFR 488.417, and enforce any denial of payment for new admissions (DPNA) issued by the Centers for Medicare & Medicaid Services.

ERAS and EFTS

Providers may register to receive their Humana electronic remittance advice (ERA) and payments/electronic funds transfer (EFT) and get paid up to seven days faster. The enrollment process is quick and easy:

- Sign into the secure provider website at **Humana.com/Providers**
- Select the "ERA/EFT Setup-Change Request"
- Complete the form

You may also access the registration form from the public portal from the Humana.com/providers page:

- Select “ERA/EFT”
- Choose the “ERA/EFT Setup-Change Request” link
- Registration requires two check numbers from claims paid by Humana for validation

Crossover claims

Effective Oct. 1, 2016, providers no longer need to send Medicare crossover claims for dually eligible recipients directly to Humana. Under this initiative, providers only need to submit their claims once to the CMS for processing and no longer are required to submit secondary claims to Humana. This means CMS will automatically forward claims for members who are dually eligible for both Medicare and Medicaid coverage.

Please note: If a provider submits a claim for a dually eligible member that CMS already has forwarded to Humana, Humana will deny the provider-submitted claim as a duplicate.

Incentive plans

Upon request, the physician agrees to disclose to Humana within a reasonable timeframe not to exceed 30 days,

or such lesser period of time required for Humana to comply with all applicable state and federal laws, rules and regulations, from such request, all of the terms and conditions of any payment arrangement that constitutes a physician incentive plan as defined by CMS and/or any state or federal law, between physician and other physicians. Such disclosure shall be in the form of a certification, or other form as required by CMS and/or AHCA, by the physician and shall contain information necessary for Humana to comply with applicable state and federal laws, rules and regulations and as requested by Humana.

Within 35 days of a request by AHCA or DHHS, physician shall disclose physician’s ownership; any significant business transactions between physician and any wholly owned supplier or subcontractor during the five year period ending on the date of the request; and the identity of any owner, agent or managing employee of the physician who has been convicted of a crime relating to any program under Medicare, Medicaid or the Title XX services program.

Cultural competency plan

Participating providers are expected to provide services in a culturally competent manner which includes, but is 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 must also 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.

Humana recognizes cultural differences and the influence that race, ethnicity, language and socioeconomic status have on the healthcare experience and health outcomes. It is committed to developing strategies that eliminate health disparities and address gaps in care.

A report by the Institute of Medicine in 2002 confirmed the existence of racial and ethnic disparities in healthcare. “Unequal Treatment” found racial differences in the

type of care delivered across a wide range of healthcare settings and disease conditions, even when controlling for socioeconomic status factors such as income and insurance coverage. Annual national healthcare disparities reports from the Agency for Healthcare Research and Quality (AHRQ) confirm that these gaps persist in the American healthcare system.

Communication is paramount in delivering effective care. Mutual understanding may be difficult during cross-cultural interaction between patients and providers.

Some disparities may be attributed to miscommunication between providers and patients, language barriers, cultural norms and beliefs and attitudes that determine health- care-seeking behaviors. Providers can address racial and ethnic gaps in

healthcare with an awareness of cultural needs and improving communication with a growing number of diverse patients.

Humana offers a number of initiatives to deliver services to all members regardless of ethnicity, socioeconomic status, culture and primary language. These include language assistance services, race and ethnicity data collection and analysis, internal staff training and Spanish resources.

Other initiatives give providers resources and materials, including tools from health-related organizations that support awareness of gaps in care and information on culturally competent care.

To request a paper copy of Humana's Cultural Competency Plan, please contact Humana customer service at

800-4HUMANA (800-448-6262) or call your provider contracting representative. The copy of Humana's Cultural Competency Plan will be provided at no charge to the provider.

Member rights and responsibilities

Member rights

1. A member has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy.
2. A member has the right to a prompt and reasonable response to questions and requests.
3. A member has the right to know who is providing medical services and who is responsible for his or her care.
4. A member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
5. A member has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English or is hearing-impaired.
6. A member has the right to know what rules and regulations apply to his or her conduct.
7. A member has privacy rights under the Health Insurance Portability and Accountability Act (HIPAA). This is a federal law that protects your health information. These rights are important for you to know. You can exercise these rights, ask questions about them and file a complaint if you think your rights are being denied or your health information isn't being protected.
8. A member has the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
9. A member has the right to participate in decisions regarding his or her healthcare, including the right to refuse treatment except as otherwise provided by law.
10. A member has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
11. A member who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate.
12. A member has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
13. A member has the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have the charges explained.
14. A member has the right to request and receive a copy of his or her medical records, and request that they be amended or corrected.
15. A member has the right to request a second opinion.
16. A member has the right to be furnished healthcare services in accordance with federal and state regulations.
17. A member has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap or source of payment.

18. A member has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
19. A member has the right to have medical records kept private and shared only when required by law or with member's approval.
20. A member has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
21. A member has the right to provide advance directives.
22. A member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
23. The state must ensure that each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member.
24. A member has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the healthcare provider or healthcare facility that served him or her and to the appropriate state licensing agency.
25. The member has the right to request a change to his or her managed care plan if the managed care plan does not, because of moral or religious objections, cover the service the member seeks.
26. The member has the right to receive information about the managed care plan, its services, its practitioners and providers and member rights and responsibilities.
27. The member has the right to make recommendations about the managed care plan's member rights and responsibilities statement.
28. A member has the right to choose a practitioner that has the same race, ethnicity, and/or language as themselves if a practitioner is available in their network.

Member responsibilities

1. A member is responsible for providing to the healthcare provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his or her health.
2. A member is responsible for reporting unexpected changes in his or her condition to the healthcare provider.
3. A member is responsible for reporting to the healthcare provider whether he or she understands a possible course of action and what is expected of him or her.
4. A member is responsible for following the treatment plan recommended by the healthcare provider.
5. The member is responsible for listening to his provider, follow instructions and ask questions.
6. A member is responsible for keeping appointments, and when he or she is unable to do so for any reason, for notifying the healthcare provider or healthcare facility.
7. A member is responsible for his or her actions if he or she refuses treatment or does not follow the healthcare provider's instructions.
8. A member is responsible for assuring that the financial obligations of his or her healthcare are fulfilled as promptly as possible.
9. A member is responsible for following healthcare facility rules and regulations affecting patient care and conduct.
10. A member is responsible to treat health care staff and case manager with respect and notify the MCO if there are problems with any health care staff.
11. The member is responsible to use the emergency room only for real emergencies.
12. The member is responsible to report fraud, abuse and overpayment.

Fraud and abuse policy

Provider must incorporate a description of the specific controls in place for prevention and detection of potential or suspected

fraud and abuse.

Provider understands and agrees to educate providers employees about the False Claims Act's prohibition on submitting false or fraudulent claims for payment, penalties for false claims and statements, whistleblower protections and each person's responsibility to prevent and detect fraud, waste and abuse.

Humana and AHCA should be notified immediately if a physician/provider or their office staff:

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

Providers may provide the above information via an anonymous phone call to Humana's Fraud Hotline at **800-614-4126**. All information will be kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Humana ensures no retaliation against callers because Humana has a zero- tolerance policy for retaliation or retribution against any person who reports suspected misconduct.

Providers may also contact Humana at **800-4HUMANA (800-448-6262)** and AHCA at **888-419-3456**, option 5.

In addition, providers may use the following contacts:

Telephonic:

- Special Investigations Unit (SIU) Direct Line: **800-558-4444** ext. 8187 (8 a.m. – 5:30 p.m. Eastern time, Monday – Friday)
- Special Investigations Unit 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
- Web: **Ethicshelpline.com**

Health, safety and welfare

Suspected cases of abuse, neglect and/or exploitation must be reported to the state's Adult Protective Services Unit.

The Florida Adult Protective Services has the responsibility for investigating allegations of abuse and neglect of elders and individuals with disabilities. This includes, but is not limited to:

- **Abuse** — Non-accidental infliction of physical and/or emotional harm.
- **Physical abuse** — Infliction of physical pain or injury upon a person.
- **Sexual abuse** — Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities; touching, fondling, sexual threats, sexually inappropriate remarks or any other sexual activity with a person when the person is unable to understand, unwilling to consent, threatened or physically forced to engage in sexual activity.
- **Psychological abuse** — Includes, but is not limited to, name calling, intimidation, yelling and swearing. May also include ridicule, coercion and threats.
- **Emotional abuse** — Verbal assaults, threats of maltreatment, harassment or intimidation intended to compel the older person to engage in conduct from which he or she wishes and has a right to abstain, or to refrain from conduct in which the older person wishes and has a right to engage.
- **Neglect** — Repeated conduct or a single incident of carelessness that 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. It 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.

- **Human trafficking** — The transportation, solicitation, recruitment, harboring, providing, or obtaining of another person for transport, the purposes of forced labor, domestic servitude or sexual exploitation using force, fraud and/or coercion.

Indicators of abuse, neglect and exploitation

Physical indicators

1. Unexplained bruises or welts:
    a. On face, lips, mouth, torso, back, buttocks, thigh in various stages of healing
    b. Reflecting shape of article used to inflict (electric cord or belt buckle) in several different surface areas
2. Unexplained fractures:
    a. To skull, nose, facial structure, in various stages of healing
    b. Multiple or spiral fractures
3. Unexplained burns:
    a. Cigar, cigarette burns, especially on palms, legs, arms, back or soles of feet
    b. Immersion burns (sock-like or glove-like shapes on feet or hands, or a doughnut-shape on buttocks that indicate that the victim was held down in hot liquid)
    c. Patterned like objects (electric burner, etc.)
4. Unexplained lacerations:
    a. Mouth, lips, gums, eye or to external genitalia
5. Sexual abuse:
    a. Difficulty in walking/sitting
    b. Torn, shredded or bloody undergarments
    c. Bruises or bleeding in external genitalia, vaginal or anal areas
    d. Venereal disease
    e. Pregnancy
6. Other:
    a. Severe or constant pain
    b. Obvious illness that requires medical or dental attention
    c. Emaciated (so that individual can hardly move or so thin bones protrude)
    d. Unusual lumps, bumps or protrusions under the skin
    e. Hair thin as though pulled out, bald spots
    f. Scars
    g. Lack of clothing
    h. Same clothing all the time
    i. Fleas, lice on individual
    j. Rash, impetigo, eczema
    k. Unkempt, dirty
    l. Hair matted, tangled or uncombed

Behavioral indicators

1. Destructive behavior of victim:
    a. Assaults others
    b. Destroys belongings of others or themselves

c. Threatens self-harm or suicide
d. Inappropriately displays rage in public
e. Steals without an apparent need for the things stolen
f. Recent or sudden changes in behavior or attitudes

2. Other behavior of victim:
    a. Afraid of being alone
    b. Suspicious of other people and extremely afraid others will harm them
    c. Shows symptoms of withdrawal, severe hopelessness, helplessness
    d. Constantly moves from place to place
    e. Frightened of caregiver
    f. Overly quiet, passive, timid
    g. Denial of problems
3. Behavior of family or caregiver:
    a. Marital or family discord
    b. Striking, shoving, beating, name-calling, scapegoating
    c. Hostile, secretive, frustrated, shows little concern, poor self-control, blames adult, impatient, irresponsible
    d. Denial of problems
    e. Recent family crisis
    f. Inability to handle stress
    g. Recent loss of spouse, family member or close friend
    h. Alcohol abuse or drug use by family
    i. Withholds food, medication
    j. Isolates individual from others in the household
    k. Lack of physical, facial, eye contact with individual
    l. Changes doctor frequently without specific cause
    m. History of similar incidents
    n. Resentment, jealousy
    o. Unrealistic expectations of individual

Human trafficking indicators

Includes, but is not limited to:

- A scripted or inconsistent history
- Unwilling or hesitant to answer questions about the injury or illness
- Accompanied by an individual who does not let the patient speak for themselves, refuses to let the patient have privacy, or who interprets for them
- Evidence of controlling or dominating relationships (excessive concerns about pleasing a family member, romantic partner, or employer)
- Demonstrates fearful or nervous behavior or avoids eye contact

- Resistant to assistance or demonstrates hostile behavior
- Unable to provide his/her address
- Not aware of his/her location, the current date or time
- Not in possession of his/her identification documents
- Not in control of his or her own money
- Not being paid or wages are withheld

Providers are required to report adverse incidents to the agency immediately, but no later than 24 hours from the incident. Reporting will include information detailing the member's identity, incident description and outcomes, including current member status. It is a provider's responsibility to ensure that abuse, neglect and exploitation training occurs and that necessary training documentation is maintained for employees that have contact with plan members. Providers may be requested to make such documentation available.

The "Adult Abuse, Neglect and Exploitation Guide for Professionals" may be used as a training tool. It is available at: **https://www.myflfamilies.com/sites/default/files/2022-11/GuideforProfessionals.pdf**

Suspected elder abuse, neglect, or exploitation may be reported 24 hours a day, seven days a week to the central abuse hotline at **800-96-ABUSE (800-962-2873)**. Online reports may be filed at: **https://reportabuse.dcf.state. fl.us/**.

When reporting suspected or confirmed abuse, neglect or exploitation, please report the following information (if available):

- Victim's name, address or location, approximate age, race and gender;
- Physical, mental or behavioral indications that the person is infirmed or disabled;
- Signs or indication of harm or injury or potential harm or injury (physical description or behavioral changes);
- Relationship of the alleged person responsible to the victim, if possible. If the relationship is unknown, a report will still be taken if other reporting criteria are met.
- Medicaid MCOs may be required to ensure that all direct care providers have knowledge of and attest they will maintain compliance with staff training relative to abuse, neglect and exploitation.

Adverse incident reporting

Humana's Risk Management Program includes adverse incident reporting and management system for critical events that negatively impact the health, safety or welfare of members.

Participating providers should:

- Identify an adverse incident. (Examples include death, wrong surgical procedure, wrong site or wrong patient, surgical procedure to remove foreign objects remaining from a surgical procedure.
- Report the adverse incident to the appropriate entity (police, adult protective services, etc.).
- Call 911 if the member is in immediate danger.
- Report the adverse incident within 24 hours of identification to the health plan and Florida Department of Children and Families.
- Report suspected abuse, neglect and exploitation of a member immediately in accordance with s.39-201 and Chapter 415, F.S.

Complete the AHCA Critical Incident Report via the AHCA Medicaid website, or download and submit the "Critical Incident Individual Report" (**https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/reports-guides/smmc-critical-incident-individual-report**) to Humana's Risk Management team via email within 24 hours of being advised of the incident at: **RiskManagementAdministration@humana.com**

Patient-centered medical home (PCMH)

PCMH is a transformative model of care that strengthens the provider-patient relationship by replacing episodic care with coordinated care and fosters greater accountability for both patient and provider.

PCMHs are expected to provide evidence-based services to patients and integrate care with specialty and subspecialty practices. The medical home is required to adhere to the following tenets:

Enhance access and continuity — Accommodate patient's needs with access and advice during and after regular office hours, give patients and their families information about their medical home and provide patients with team- based care.

Identify and manage patient populations — Collect and use data for population management.

Plan and manage care — Use evidence-based guidelines for preventive, acute and chronic care management, including medication and mental health management.

Provide self-care support and community resources — Assist patients and their families in self-care management with information, tools and resources.

Track and coordinate care — Track and coordinate tests, referrals and transitions of care.

Measure and improve performance — Use performance and patient experience data for continuous quality improvement.

Humana Healthy Horizons in Florida's PCMH program works to empower patients as they interact with their PCPs and healthcare delivery teams (e.g., family, therapist, specialist, diagnostic center, hospital and laboratory). The PCMH program focuses on a team-based approach to healthcare delivery. Open communications between the healthcare team and patient allow for the patient to be more actively involved in healthcare decisions with a potential for better health outcomes and cost-effective treatment of ongoing health conditions.

According to AHRQ, a PCMH program includes the following functions that transform traditional primary care into advanced primary care:

- Comprehensive care — A team that includes physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators and care coordinators, guides patients through the healthcare delivery system.
- Patient-centered care — The patient is primary in the relationship and drives decisions that influence his or her health. Physicians provide education and establish a plan of care.
- Coordinated care — The PCP communicates with the healthcare delivery team and manages coordination of care.
- Accessible services — The patient's access-to-care preferences are important. Shorter wait times, urgent needs, after-hours and around-the-clock access, as well as openness to different types of communication besides the telephone, are taken into consideration by the physician.
- Quality and safety — The PCP uses evidence-based medicine and clinical decision-support tools to guide the patient and healthcare delivery.

PCPs who are interested in the PCMH program, certification requirements and the benefits may email **pcmh@humana.com**.

Provider rewards and incentives

Provider Quality Bonus — Program aims to promote improvement and quality by providing additional financial compensation to PCP centers that demonstrate high levels of performance for select quality factors.

Eligibility

- PCP must have an open panel for Medicaid line of business.
- PCP serves a minimum of 50 Medicaid member assignments.

MMA Physician Incentive Program (MPIP)

The MMA Physician Incentive Program's aim is to promote quality of care for Medicaid members and recognize those physicians who demonstrate high levels of performance for selected criteria. The MPIP provides the opportunity for designated physician types to earn enhanced payments equivalent to the appropriate Medicare fee-for-service rate, as established by the AHCA based on the achievement of key access and quality measures. To learn more about this program, including whether you qualify, please contact your provider contracting representative.

Provider resource website

Providers may obtain plan information from **Humana.com/Providers**.

This information includes, but is not limited to, the following:

- Claims Payment Policies
- Claims Processing Edits
- Claims Resources
- Contracting with Humana
- Credentialing
- Drugs Prior Authorizations
- EFT/ERA Resources
- Preauthorization/referrals
- Provider Covid 19
- Provider Pharmacy Materials
- Provider Quality Resources
- Self-service Portal

Medicaid educational resources and updates are available for providers at **Humana.com/HealthyFL**, including:

- FL Medicaid Provider Handbook
- Provider Resource Guide
- FL Medicaid Benefits
- Billing guides
- Provider Newsletters
- Additional provider training resources

Humana Making It Easier "Making It Easier for Physicians and Other Healthcare Providers" is a series of educational presentations about Humana's claims payment policies and processes. Visit **Humana.com/MakingItEasier**. Also accessible at **Availity.com** in the Humana Payer Space under the Resources tab.

Provider training

Providers are expected to take all training identified by the contract during initial orientation. All training must be completed within the first 30 days of being contracted for Medicaid. Providers must also ensure that their affiliated participating providers and staff members are trained on mandatory compliance materials.

As part of the training requirements, providers must complete compliance training on the following topics:

- Florida Medicaid Provider Orientation Training
- Compliance and Fraud, Waste and Abuse
- Cultural Competency
- Health, Safety and Welfare (Abuse, Neglect and Exploitation)

Providers are also expected to complete training on compliance and fraud, waste and abuse and implement specific controls for the prevention and detection of potential or suspected fraud and abuse as required by s. 6032 of the federal Deficit Reduction Act of 2005.

Providers and authorized users can access these online training modules 24 hours a day, seven days a week at **Availity.com**. Sign in with your existing user ID and password.

If the appropriate person does not already have access to Availity, your organization's administrator may create a new user. Choose "**Payer Spaces" | Humana, select the "Resources tab," select "Humana Compliance Events."**

For additional provider training, visit **https://www.humana.com/provider/medical-resources/medicare-medicaid/florida-medicaid/compliance-training-materials** .

Availity Essentials

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

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

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

Helpful numbers

Medicaid customer service: Please call the number on the back of the member's ID card for the most efficient call routing.

- MMA Provider Relations: **800-477-6931** 8 a.m. – 5 p.m., Central Time, Monday – Friday
- Prior authorization (PA) assistance for medical procedures: **800-523-0023**, 8 a.m. – 8 p.m., Eastern time, Monday – Friday
- Prior authorization for medication billed as medical claim: **866-461-7273**, 8 a.m. – 6 p.m., Eastern time, Monday – Friday
- Prior authorization for pharmacy drugs: **800-555-2546**, 8 a.m. – 6 p.m. local time, Monday – Friday
- Medicaid case management: **800-229-9880**
- Medicaid concurrent review: **800-322-2758**
- Clinical management program information: **800-491-4164**
- PrescribeIT: **800-526-1490**
- Availity Essentials customer service/tech support: **800-282-4548**, 8 a.m. – 8 p.m., Eastern time, Monday - Friday
- Ethics and compliance concerns: **877-5-THE-KEY (877-584-3539)**
- You can find related materials here **https://www.humana.com/provider/medical-resources/medicare-medicaid/florida-medicaid/compliance-training-materials**

Humana Healthy Horizons in Florida long-term care/Humana Healthy Horizons in Florida comprehensive plan

Introduction

If you have a patient/member who is enrolled in both Humana Healthy Horizons in Florida's MMA and long- term care, the plan name is Humana Healthy Horizons in Florida Comprehensive Plan. Humana Healthy Horizons in Florida Comprehensive Plan covers both medical and long-term care services. A patient/member who is enrolled in a Medicare Dual Eligible Special Needs Plan (DSNP) can receive long-term care services from Humana Healthy Horizons in Florida Long-Term Care Plan.

Section I of this handbook, Humana Healthy Horizons in Florida Medical Plan, describes information for providers who are rendering medical services.

Section II of this handbook, Humana Healthy Horizons in Florida Long-Term Care/Humana Healthy Horizons in Florida Comprehensive Plan, describes information for providers who are rendering long-term-care services.

Humana Healthy Horizons in Florida's long-term-care managed care plan works directly with the state of Florida to provide our members with community and/or facility care with a focus to coordinate the member's primary care through his/her primary insurance. Humana is a statewide contractor for this program, allowing our membership to freely move to any county they choose in the state.

Our first goal is to keep our members in their homes and provide home healthcare and community-based services that may delay or avoid long-term placement in a nursing facility. If our members need a more supervised environment or want more socialization, we will facilitate services in an assisted living facility or an adult family home. We understand that some of our members will require nursing home care; we will help members transition to this level of care when it is no longer safe to remain in a community setting. We facilitate care that meets the individual needs of each of our members.

The state of Florida's goals for this program are:

- Provide coordinated long-term care across different healthcare settings
- Ensure members' choice of the best long-term-care plan for their needs
- Create long-term-care plans with the ability to offer more services
- Provide access to cost-effective community-based long- term-care services

Humana Healthy Horizons in Florida has established guidelines to assist you in understanding the goals of our program. This handbook will provide you with vital information needed to develop and maintain an effective relationship as we work to meet members' needs.

Statewide Medicaid Managed Care

The SMMC program is designed to care for all eligible individuals in a nursing home or a less restrictive environment in the community. Eligibility requirements are:

- 18 or older
- Reside in the state of Florida
- Meet physical and financial requirements as determined by the state

AHCA was required to change how some individuals receive healthcare from the Florida Medicaid program to implement this program. The changes to Florida Medicaid were made because of National Healthcare Reform or the Affordable Care Act passed by the U.S. Congress.

There are two different components that make up Medicaid Managed Care:

- The Florida LTC managed care program
- The Florida MMA program

Medicaid recipients who qualify and become enrolled in the Florida LTC managed care program will receive long-term care services through a comprehensive managed care plan or a long-term care plus managed care plan. Humana Healthy Horizons in Florida is a comprehensive managed care plan approved in all 11 regions of the state of Florida to provide medical and long-term-care services to eligible members.

Medicaid recipients who qualify and become enrolled in the Florida MMA program will receive all healthcare services other than long-term care through a managed care plan. All Humana Healthy Horizons in Florida Comprehensive Plan members will be enrolled in Humana Healthy Horizons in Florida's comprehensive managed care plan, and Humana Healthy Horizons in Florida will be responsible for providing long- term care services, medical services as well as coordinating Medicare benefits if the recipient is dual eligible.

For more information on the Florida Long-term Care Managed Care program, please visit the AHCA website at: **https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/long-term-care-program**.

Long-term care managed care program

Humana is proud to participate as a contractor for the state of Florida to operate a Medicaid-funded program known as the long-term-care managed care program. Medicaid is a program for eligible individuals and/or families with low incomes and resources. It is a means- tested program that is jointly funded by the state and federal governments and is managed by the state.

Medicaid is the largest source of funding for medical and health-related services for people with limited income in the United States. People served by Medicaid must be U.S. citizens or legal permanent residents, and may include low-income adults, their children and people with certain disabilities. Poverty alone does not necessarily qualify someone for Medicaid.

The long-term-care managed care program is designed to care for all eligible individuals 18 and older who meet a level of care that requires nursing home care, as well as a financial criterion; both qualifications are determined by the state. The program provides eligible individuals with access to care in a nursing home or a less restrictive environment in the community. The program seeks to reduce the number of individuals residing in nursing homes so they may be cared for in less-restrictive environment while also creating cost savings for the state.

Practice guidelines

Humana has adopted practice guidelines that are incorporated in our policy and procedures, as well as our daily business practices.

Practice guideline requirements are designed with the following in mind:

- Guidelines must be based on valid and reliable clinical evidence or a consensus of healthcare professionals in the geriatric and disabilities fields.
- Guidelines are adopted based on the needs of the members.
- Guidelines are adopted after consultation with contracted healthcare professionals, when necessary.
- Guidelines are reviewed and updated periodically, as appropriate.
- Humana will disseminate the guidelines to all affected providers and, upon request, to members and potential members.
- Decisions for utilization management, member education, coverage of services and other areas to which these guidelines apply will be consistent throughout the policy and procedure manual and daily business practices.

Mission statement

We provide the highest quality services to our members by a team of motivated, invested associates and leaders, driving outstanding customer experiences while pioneering simplicity and exceeding stakeholder expectations. Thriving together to achieve positive outcomes through innovative solutions and best practices.

Hours of operation

Our dedicated staff is available to answer questions 8 a.m. to 8 p.m., Eastern time, Monday through Friday. If you have questions regarding services or benefits, please call the Provider Help Line at **888-998-7735**.

Humana Healthy Horizons in Florida LTC comprehensive plan website

Humana.com/FLLTC

The Humana Healthy Horizons in Florida comprehensive plan website is designed to give providers quick access to current provider and member information 24 hours a day, seven days a week. You also will find additional program and Humana Healthy Horizons in Florida comprehensive plan information. Please contact your local provider contracting representative if you have questions or concerns regarding the website.

Confidentiality statement

Humana maintains a policy to ensure that medical records, claim information and grievances pertaining to members and providers remain confidential. The authorized release of information is used only for the resolution of medical problems or to enhance a member's health. Humana will ensure compliance with the privacy and security provisions of the HIPAA.

Eligibility

Enrollment in Humana Healthy Horizons in Florida's LTC plan is based on standards of eligibility established by the Department of Elder Affairs (DOEA) and Comprehensive Assessment and Review for Long- term Care Services (CARES). Financial eligibility is based on standards of eligibility established by the Florida DCF.

Conditions of LTC enrollment

Recipients eligible for enrollment must:

- Be 18 years of age or older
- Reside in Florida
- Be determined by CARES to be at risk of nursing home placement, meet specific clinical criteria and may be safely served with home and community-based services
- Be determined by DCF to be financially eligible. (Financial eligibility for the program is the same as the Medicaid Institutional Care program [ICP].)

For specific information regarding eligibility criteria, you may contact your provider contracting representative or care management in your region.

Medicaid pending

Individuals designated as "Medicaid pending" are those who have applied for the program and have been determined medically eligible by CARES but have not been determined financially eligible for Medicaid by DCF.

Humana Healthy Horizons® in Florida has elected to provide services to these individuals who reside in the community and assist them with completing and returning applications to DCF. If DCF determines an individual is not financially eligible for Medicaid, Humana Healthy Horizons in Florida will terminate services and seek reimbursement from the individual who signed the financial agreement on the member's behalf. The individual will receive an itemized bill for services received from the Humana Healthy Horizons in Florida Comprehensive Plan during the ineligible span.

If a Medicaid-pending member resides in a nursing home, the facility is required to assist with the Medicaid-pending process.

Membership identification (ID) card

Each member receives a Humana Healthy Horizons in Florida Comprehensive Plan member identification (ID) card. If the card is lost or stolen, the member may contact his or her care manager. Members can also access their ID card through the MyHumana website or mobile app.

A sample member ID card is below.

Referrals to Humana Healthy Horizons in Florida LTC/Humana Healthy Horizons in Florida comprehensive plan

If an individual believes he or she may qualify to participate in the program, the individual or the individual's representative must contact the local Aging & Disability Resource Center (ADRC) office to apply for the Humana Healthy Horizons in Florida Comprehensive Plan. As a provider, if you decide to assist the individual with the application process, you must obtain the individual's consent. To obtain a consent form, please visit **flmedicaidmanagedcare.com**. Choose the "Click Here" to download the Authorized Representative Form" link at the top of the screen. The individual or the provider is welcome to contact Humana Healthy Horizons in Florida for program information at any time. To locate an ADRC office in your area, please refer to the appendix.

Member disenrollment

Disenrollment with cause

If a member is a mandatory member and wants to change plans after the initial 90-day period ends or after the open enrollment period ends, the member must have a state-approved for-cause reason to change plans.

The agency will review and determine approval of the member's request. More information is available from the enrollment broker by calling **877-711-3662**.

The following are potential for-cause reasons to change managed care plans:

- The member does not live in a region where the managed care plan is authorized to provide services, as indicated in the Florida Medicaid Management Information System (FMMIS).
- The provider is no longer with the managed care plan.
- The member is excluded from enrollment.
- A substantiated marketing or community outreach violation has occurred.
- The member is prevented from participating in the development of his/her treatment plan/plan of care.
- The member has an active relationship with a provider who is not on the managed care plan's panel but is on the panel of another managed care plan. "Active relationship" is defined as having received services from the provider within the six months preceding the disenrollment request.

- The member is in the wrong managed care plan as determined by the agency.
- The managed care plan no longer participates in the region.
- The state has imposed intermediate sanctions upon the managed care plan, as specified in 42 CFR 438.702(a)(3).
- The member needs related services to be performed concurrently, but not all related services are available within the managed care plan network, or the member's PCP has determined that receiving the services separately would subject the member to unnecessary risk.

Covered services

Humana Healthy Horizons in Florida Comprehensive Plan provides coverage for members who are enrolled in our LTC managed care program and our MMA program. Please refer to Section I Humana Healthy Horizons in Florida Medical Plan for providers who are rendering medical services. Long-term care coverage is limited to those services authorized in writing by the member's care manager and in accordance with AHCA Medicaid Services Coverage and Limitations handbooks. Covered services include:

- The managed care plan does not, because of moral or religious objections, cover the service the member seeks.
- The member missed open enrollment due to a temporary loss of eligibility, defined as 60 days or less for LTC members and 180 days or less for MMA members.
- Other reasons per 42 CFR 438.56(d)(2) and s. 409.969(2), F.S., including, but not limited to, poor quality of care, lack of access to services covered under the contract, inordinate or inappropriate changes of PCPs, service access impairments due to significant changes in the geographic location of services, an unreasonable delay or denial of service, lack of access to providers experienced in dealing with the member's healthcare needs, or fraudulent enrollment.

Some Medicaid recipients may change managed care plans whenever they choose, for any reason. To find out if a member may change plans, call the enrollment broker at **877-711-3662**.

Adult companion care

- Adult day healthcare
- Assistive care services
- Assisted living
- Attendant care
- Behavioral management
- Caregiver training
- Care coordinator/case management
- Home accessibility adaptation services
- Home delivered meals
- Home maker services
- Hospice
- Intermittent and skilled nursing
- Medical equipment and supplies
- Medication administration
- Medication management
- Nutritional assessment/ risk reduction services
- Nursing facility services
- Personal care
- Personal emergency response system (PERS)
- Respite care
- Occupational therapy
- Physical therapy
- Respiratory therapy
- Speech therapy
- Transportation

A member has the option to disenroll without cause

If a member must join a managed care plan and is subject to open enrollment, a member may ask to leave the managed care plan without cause. A member can submit this request to the agency or its enrollment broker. A member may disenroll from the Humana Healthy Horizons in Florida Comprehensive Plan without cause in the following situations:

- During the 90 days following the member's initial enrollment, or the date the agency or its agent sends the member notice of the enrollment, whichever is later;
- At least every 12 months;
- If the temporary loss of Medicaid eligibility has caused the member to miss the open enrollment period
- When the agency or its agent grants the member the right to terminate enrollment without cause (done on a case-by-case basis)
- During the 30 days after the member is referred for hospice services to enroll in another managed care plan to access the member's choice of hospice provider.

Medically necessary/medical necessity

Medically necessary care or medical necessity is determined, as per 59G-1.010(166), Florida Administrative Code (FAC), as follows. "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
- Be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker or the provider.

"Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service.

Emergency service responsibilities

If a member requires emergency acute care services, contact the member's primary insurance for precertification or send the member to the emergency room as deemed appropriate. Please contact the member's assigned care manager or the Humana Healthy Horizons in Florida Comprehensive Plan customer service department once the emergency is addressed. This will allow the care manager to follow up with coordinated care.

Adult day care

This service provides members with supervision, socialization and therapeutic activities in an outpatient setting. This also provides caregivers with respite. Meals are included as part of this service when the member is at the center during meal times. Adult day care health services include, but are not limited to, the following:

- Supervised, recreational activities at least 80% of the day
- Physical exercises
- Cognitive exercises
- Lunch and snacks
- Coordination of transportation
- Medication administration and management

- Vital signs monitoring
- Basic health monitoring, including glucose level checks
- Referral to physical therapy screening (conducted on- site)
- Hands-on assistance with personal care, such as toileting, eating, ambulating and grooming

Assistive care

Assistive care offers 24-hour services for members in assisted living facilities, adult family care homes and residential treatment facilities. Services include:

- 24-hour access to staff
- Assistance with ambulation
- Assistance with transferring
- Assistance with eating
- Dementia care
- Dressing and grooming
- Emergency/disaster plan
- Escort services
- Housekeeping
- Incontinence management
- Medication management
- Personal laundry and linen services
- Three meals per day, plus snacks
- Transportation
- Utilities
- Wander guard

Assisted living facility (ALF)

This service provides members with an alternative living arrangement where there is access to 24-hour staff in a "home-like" environment for members. Meals, personal care and housekeeping services are provided by the staff. The facility may be used for respite care. The community will provide members with the following services or as indicated in each individual provider contract:

- 24-hour access to staff
- Bathing assistance
- Medication management
- Three meals per day, plus snacks
- Incontinence management
- Incontinence supplies
- Nutritional supplements
- Housekeeping
- Personal laundry and linen service
- Utilities
- Transportation or coordination of transportation
- Alarmed doors or locked unit
- Personal hygiene items
- Escort to dining room
- Emergency/disaster plan
- Dementia care

Transportation — All Humana Comprehensive Plan contracts with ALFs require the ALF to coordinate transportation for members. Humana Healthy Horizons in Florida Comprehensive Plan members are eligible for transportation trips to long-term-care-covered services as authorized by Humana Healthy Horizons in Florida. Please contact the member's care manager for

authorization approval. Our members will use their health plan ID card for all covered transportation services (including emergency transportation).

Behavioral management

This service provides behavioral healthcare services that help address mental health or substance abuse needs of long-term care members. The services are used to maximize reduction of the member's disability and restoration to the member's best functional level.

Home accessibility adaptation services

These services provide members with home modifications that promote safety. This includes the installation of grab bars, ramps and widening of doors, modification of bathroom facilities or installation of specialized electric and plumbing systems to accommodate the medical equipment and supplies necessary for the welfare of the member. These services exclude home modifications that may be considered home improvements. All services must be provided in accordance with applicable state and local building codes.

Members or caregivers will be contacted within two business days of receipt of authorization from the Humana Healthy Horizons in Florida Comprehensive Plan care manager to schedule an appointment.

Home-delivered meals

This service provides nutritionally sound meals to members who are unable to shop or cook. Meals are delivered to the home hot, cold, frozen, dried or canned, with a satisfactory storage life. Each meal is designed to provide one-third of the recommended dietary allowance (RDA). A signature must be obtained from the member or caregiver upon delivery of meals. Members coordinate changes to their meal delivery through their care manager.

Home healthcare (HHC)

Providers contracted with the Humana Healthy Horizons in Florida Comprehensive Plan must adhere to the following procedures when providing services:

- Humana Healthy Horizons in Florida reserves the right to determine the plan of care for its members and will send a request of specific services and frequency to meet the member's needs. Services may be provided in a member's home or an assisted living facility on an hourly or per-visit fee as authorized by Humana Healthy Horizons in Florida. The HHC provider has a maximum of two hours to inform Humana Healthy Horizons in Florida Comprehensive Plan staff if the requested services can be provided and the anticipated start date.
- HHC staff are required to have the agency's designated form signed by the member verifying that the services were provided at the time of each visit, including date/ time of service and direct care staff who provided the service.
- In compliance with the 21PstP Century CURES Act, providers are required to utilize EVV to electronically monitor, track, and confirm services provided in the home setting.
- If a Humana Healthy Horizons in Florida Comprehensive Plan member is entitled to Medicare home health benefits, these benefits will be utilized prior to services being authorized under your contract with the Humana Healthy Horizons in Florida Comprehensive Plan.
- Missed visits are to be documented within EVV and reported within a 3 hour window from when services are to be rendered.

Home health services are authorized by the care manager on a weekly basis (Sunday through Saturday). Preauthorization is required by the care manager to provide services that exceed the number of hours authorized in a day or in a week. The only variation that is allowable without preauthorization is to switch the days of services within the same week, with prior authorization of the member. If the schedule change is permanent, the provider should inform the care manager of the change.

Adult companion — Companions can perform tasks, such as meal preparation, laundry and shopping, while providing socialization for the member. This includes light housekeeping tasks incidental to the care and supervision of the member. Services do not include hands-on nursing care or bathing assistance.

Family training — This service provides training to family members to promote safety while caring for the member. This

includes education regarding diabetes management, transferring an individual and how to use safety equipment properly.

Homemaker services — This service provides members with assistance with general household activities to include meal preparation, laundry and light housekeeping.

Occupational therapy — This service provides members with treatment to restore, improve or maintain impaired function regarding daily living tasks (e.g., using a fork, using a shower chair or cooking from a wheelchair).

Personal care — This service provides members with assistance with bathing, dressing, eating, personal hygiene and other activities of daily living. A personal care worker can do incidental housekeeping, such as making beds and cleaning up areas where they have performed services.

Physical therapy — This service provides members with treatment to restore, improve or maintain impaired function in regard to ambulation and mobility such as walking, transferring or using a walker or wheelchair.

Respite care — This service provides caregivers with relief for short periods of time. Respite care may be provided by a home health agency, assisted living community or a skilled nursing facility. Respite care is not a substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist.

Hospice

This service provides forms of palliative medical care and services designed to meet the physical, social, psychological, emotional and spiritual needs of terminally ill members and their families. Care managers will coordinate this care with members enrolled in Medicare hospice services. If a member requires any hospice service traditionally covered by Medicaid, preauthorization may be required from the care manager.

Members can be simultaneously enrolled in Humana Healthy Horizons in Florida Comprehensive Plan and hospice. Medicaid hospice services require prior approval from Humana. Dual-eligible members may enroll in Medicare hospice. The care manager will assist to coordinate services. Members or their representatives are required to contact the Humana Healthy Horizons in Florida Comprehensive Plan care manager before enrolling in a hospice program.

Medical supplies (Consumable)

This service provides members and caregivers with supplies that assist in meeting members' needs. Items include incontinent supplies and diabetic supplies not covered by Medicare. These services do not include personal toiletries, over-the-counter medications or household items.

Consumable medical supplies include adult disposable diapers, tubes of ointment, cotton balls and alcohol for use of injections, medicated bandages, gauze and tape, colostomy and catheter supplies and other consumable supplies. Not included are supplies covered under home health service, personal toiletries and household items, such as detergents, bleach, paper towels or prescription drugs.

Services require written authorization from the Humana Healthy Horizons in Florida Comprehensive Plan care manager. Supplies will be delivered to the member's home and the member or caregiver will sign an itemized receipt. Members must go through their care manager to make changes to an order. Nutritional supplements require both a physician's prescription and preauthorization from the Humana Healthy Horizons in Florida Comprehensive Plan care manager. Members authorized to live in a contracted facility will receive this service directly from the facility.

Medical supplies (DME)

DME is medical equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful in the absence of illness or injury and is appropriate for use in the recipient's home. Medicare and Medicaid acute-care programs cover most DME that Humana Healthy Horizons in Florida Comprehensive Plan members need. Items needed by Humana Healthy Horizons in Florida Comprehensive Plan members that are not covered by Medicare require preauthorization from the Humana Healthy Horizons in Florida Comprehensive Plan care manager.

Skilled nursing facility (SNF) services

SNF services are coordinated with members' acute-care coverage. If members are dually eligible for Medicare and Medicaid, the Humana Healthy Horizons in Florida Comprehensive Plan is responsible for coinsurance as per the Medicaid crossover guidelines.

Claims must be submitted with the Medicare explanation of benefits (EOB).

The SNF staff is expected to inform Humana Healthy Horizons in Florida Comprehensive Plan staff of changes or concerns identified while providing services to members to ensure that members' needs are being met.

Respite care — Respite care provides caregivers with relief for short periods of time. Respite care may be provided by a SNF. Respite care is not a substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist.

Transportation — All Humana Healthy Horizons in Florida Comprehensive Plan contracts with SNFs require the SNF to coordinate transportation for our members. Humana Healthy Horizons in Florida Comprehensive Plan members are eligible for transportation to long-term-care-covered services, as authorized by Humana. Please contact the member's care manager for authorization approval. Our members will use their health plan ID card for all covered transportation services (including emergency transportation).

Change in member needs — Providers will inform Humana Healthy Horizons in Florida Comprehensive Plan staff of changes or concerns they identify while providing services to members to ensure that members' needs are being met. This includes notification of members being admitted to a hospital and/or going to a Medicare or Medicaid hospice program. Medicaid hospice services require preauthorization from Humana. Notification must be provided within 24 hours of a significant change in members' healthcare needs.

Custodial care — All members requiring this service must be assessed and a determination must be made by Humana that the member no longer can live in a less restrictive setting. Members who receive approval for placement in a contracted skilled nursing facility for custodial care are required to pay the facility a patient responsibility amount based on their income, which is determined by the Department of Children and Families. Prior authorization is required by Humana.

Nutritional assessment/risk reduction

This service provides members with an assessment, hands- on care and guidance for the caregiver and members with respect to nutrition. Nutritional assessments are provided by dietitians, usually from a home health agency. Humana reserves the right to determine the plan of care for its members and will send a request for specific services and frequency to meet members' needs. Services may be provided in members' homes or assisted living facilities on a 15-minute increment fee as authorized by Humana.

Personal emergency response system (PERS)

This includes the installation and service of an electronic device that enables members at high risk of institutionalization to secure help in an emergency.

The PERS is connected to the member's phone and programmed to signal a response center once a "help" button is activated. The member also may wear a portable "help" button to allow for mobility. PERS services generally are limited to those members who live alone or are alone for a significant part of the day and who otherwise would require extensive supervision. Providers will train Humana Healthy Horizons in Florida Comprehensive Plan members on the use and monthly testing of the unit upon installation and will notify Humana via telephone or fax if a member utilizes the system.

Providers are expected to install a medical alert system within five business days after receiving written authorization from a Humana Healthy Horizons in Florida Comprehensive Plan care manager.

Pharmacy benefits

The Humana Healthy Horizons in Florida Comprehensive Plan provides OTC medication benefit for our members. This benefit is obtained through our mail-order pharmacy, PrescribeIT. Our OTC order form is available upon request. Refer to the member handbook for additional information.

Transportation

Humana Healthy Horizons in Florida Comprehensive Plan members are eligible for transportation to long-term-care- covered services, as authorized by Humana. Please contact the plan for authorization approval. Our members will use their health plan ID card for all covered transportation services (including emergency transportation).

Transportation for nonmedical appointments can be provided for services but require preauthorization. Please contact the members' assigned care managers for more details.

Quality enhancements

Quality enhancement is education and/or community- based services that are coordinated by the care manager to address concerns related to safety in the home and fall prevention, disease management, education on end-of-life issues, advance directives and domestic violence.

Expanded services

Expanded services are those services offered by Humana Healthy Horizons in Florida and approved in writing by the agency.

Such expanded benefits are those services or benefits not otherwise covered or that exceed limits outlined in the Medicaid State Plan and the Florida Medicaid Coverage and Limitations handbooks and the Florida Medicaid Fee Schedules. These services are in excess of the amount, duration and scope of those services listed above. In instances in which an expanded benefit is also a Medicaid covered service, the managed care plan shall administer the benefit in accordance with any applicable service standards pursuant to this contract, the Florida Medicaid State Plan and any Medicaid Coverage and Limitations handbooks. Humana Healthy Horizons in Florida members have specific enhanced benefits. Please see the member handbook for benefit descriptions and details.

Care management

The care management team provides assistance to members to help them live in the least restrictive environment that safely meets their long-term-care needs. If a member's needs cannot be met safely in a home or assisted living facility, the care manager will assist with placement and monitoring in a nursing home.

The care manager is responsible for developing an individualized plan of care that meets each member's needs in a safe environment. Long-term-care services and supplies must be preauthorized by the care management team before they can be provided to a Humana Healthy Horizons in Florida Comprehensive Plan member. Contact the local care management team with requests for prior authorizations.

Care managers can assist members with:

- Assessments
- Coordination of care
- Authorization for services (See "Procedures for Authorization of Services")
- Change in services
- Discharge planning from inpatient services
- Transition between residential settings
- Eligibility (financial and level of care)
- Obtaining a replacement ID card
- Concerns or questions about care

Authorizations

If a member needs services, a care manager will issue an authorization for covered services to a participating provider. Our care managers will assess members' needs prior to ordering services.

Procedures for authorization of services

- Upon determination that a member needs services from a facility or company, the care management team will contact the provider to inquire if the services can be provided and provide an authorization. The authorization is valid

for the period of time specified or otherwise indicated on the authorization. If dates of services are not established, the provider's staff is responsible for following up with the plan with the date that services will begin.

- If a member needs to stop services for a short period of time (e.g., due to a hospitalization), the care management team will fax an updated authorization to the provider.
- If a member no longer needs services from the provider, the care management team will fax a termination of services authorization to the provider.
- If a member needs an increase or decrease in services, the care management team will fax an updated authorization to the provider.

If you have questions or concerns about a member, please contact our local care management team.

Health, safety and welfare

Suspected cases of abuse, neglect and/or exploitation must be reported to the state's adult protective services unit.

Florida Adult Protective Services has the responsibility for investigating allegations of abuse and neglect of elders and individuals with disabilities. This includes, but is not limited to:

- **Abuse** — Non-accidental infliction of physical and/or emotional harm.
- **Physical abuse** — The infliction of physical pain or injury upon an older person.
- **Sexual abuse** — Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities; touching, fondling, sexual threats, sexually inappropriate remarks or any other sexual activity with an older person when the older 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 older person to engage in conduct from which he or she wishes and has a right to abstain, or to refrain from conduct in which the older person wishes and has a right to engage.
- **Neglect** — Repeated conduct or a single incident of carelessness that 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. It 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.
- **Human trafficking** — transporting, soliciting, recruiting, harboring, providing, or obtaining of another person for transport; for the purposes of forced labor, domestic servitude or sexual exploitation using force, fraud and/ or coercion.

Indicators of Abuse, Neglect and Exploitation Physical indicators

1. Unexplained bruises or welts:
    a. On face, lips, mouth, torso, back, buttocks, thigh in various stages of healing
    b. Reflecting shape of article used to inflict (electric cord or belt buckle) in several different surface areas
2. Unexplained fractures:
    a. To skull, nose, facial structure, in various stages of healing
    b. Multiple or spiral fractures
3. Unexplained burns:
    a. Cigar, cigarette burns, especially on palms, legs, arms, back or soles of feet
    b. Immersion burns (sock-like and glove-like burn shapes on feet or hands, doughnut-shaped on buttocks)
    c. Patterned like objects (electric burner, etc.)
4. Unexplained lacerations:

a. Mouth, lips, gums, eye or to external genitalia

5. Sexual abuse:
    a. Difficulty in walking/sitting
    b. Torn, shredded or bloody undergarments
    c. Bruises or bleeding in external genitalia, vaginal or anal areas
    d. Venereal disease
    e. Pregnancy
6. Other:
    a. Severe or constant pain
    b. Obvious illness that requires medical or dental attention
    c. Emaciated (so that individual can hardly move or so thin bones protrude)
    d. Unusual lumps, bumps or protrusions under the skin
    e. Hair thin as though pulled out, bald spots
    f. Scars
    g. Lack of clothing
    h. Same clothing all of the time
    i. Fleas, lice on individual
    j. Rash, impetigo, eczema
    k. Unkempt, dirty
    l. Hair matted, tangled or uncombed

Behavioral indicators

1. Destructive behavior of victim:
    a. Assaults others
    b. Destroys belongings of others or themselves
    c. Threatens self-harm or suicide
    d. Inappropriately displays rage in public
    e. Steals without an apparent need for the stolen items
    f. Recent or sudden changes in behavior or attitudes
2. Other behavior of victim:
    a. Afraid of being alone
    b. Suspicious of other people and extremely afraid others will harm them
    c. Shows symptoms of withdrawal, severe hopelessness, helplessness
    d. Constantly moves from place to place
    e. Frightened of caregiver
    f. Overly quiet, passive, timid
    g. Denial of problems
3. Behavior of family or caregiver:
    a. Marital or family discord
    b. Striking, shoving, beating, name-calling, scapegoating
    c. Hostile, secretive, frustrated, shows little concern, poor self-control, blames adult, impatient, irresponsible

d. Denial of problems
e. Recent family crisis
f. Inability to handle stress
g. Recent loss of spouse, family member or close friend
h. Alcohol abuse or drug use by family
i. Withholds food, medication
j. Isolates individual from others in the household
k. Lack of physical, facial, eye contact with individual
l. Changes doctor frequently without specific cause
m. History of similar incidents
n. Resentment, jealousy
o. Unrealistic expectations of individual

Member encounter includes, but is not limited to:

- A scripted or inconsistent history
- Unwilling or hesitant to answer questions about the injury or illness
- Accompanied by an individual who does not let the patient speak for themselves, refuses to let the patient have privacy, or who interprets for them
- Evidence of controlling or dominating relationships (excessive concerns about pleasing a family member, romantic partner or employer)
- Demonstrates fearful or nervous behavior or avoids eye contact
- Resistant to assistance or demonstrates hostile behavior
- Unable to provide his/her address
- Not aware of his/her location, the current date or time
- Not in possession of his/her identification documents
- Not in control of his or her own money
- Not being paid or wages are withheld

Providers are required to report adverse incidents to the agency immediately but not more than 24 hours after identifying the incident. Reporting will include information including the member's identity, description of the incident and outcomes including current status of the member. It is your responsibility as the provider to ensure that abuse, neglect and exploitation training occurs and to maintain necessary documentation of this training for the employees that have contact with the plan (managed care organization) members. You may be requested to make such documentation available.

You may use the "Adult Abuse, Neglect and Exploitation Guide for Professionals" as a training tool. It is available at: **https://www.myflfamilies.com/sites/default/files/2022-11/GuideforProfessionals.pdf** .

Suspected elder abuse, neglect, or exploitation may be reported 24 hours a day, seven days a week to the central abuse hotline at **800-962-ABUSE (800-962-2873)**. You also can make a report online at: **https://reportabuse.myflfamilies.com/s/**.

When reporting suspected or confirmed abuse, neglect, or exploitation, please report the following information (if available):

- Victim's name, address or location, approximate age, race and gender;
- Physical, mental or behavioral indications that the person is infirmed or disabled;
- Signs or indication of harm or injury or potential harm or injury (physical description or behavioral changes);
- Relationship of the alleged person responsible to the victim, if possible. If the relationship is unknown, a report will still be taken if other reporting criteria are met.
- Medicaid managed care organizations may be required to ensure that all direct care providers have knowledge of and attest they will maintain compliance with staff training relative to abuse, neglect and exploitation.

Critical incident reporting

Critical incidents must be reported to Humana Healthy Horizons in Florida Comprehensive Plan care management within 24 hours of the incident. A critical incident is defined as an adverse or critical event that negatively impacts the health, safety or welfare of a member. Critical incidents may include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing or major medication incidents. ALF and SNF need to report abuse, neglect or exploitation incidents to Humana. Critical incidents involving abuse, neglect or exploitation also must be reported by the provider to Adult Protective Services.

Providers are expected to work with Humana Healthy Horizons in Florida Comprehensive Plan staff to resolve all identified critical incidents in a timely manner and support the safety and well-being of our members.

Humana's Risk Management Program includes adverse incident reporting and a management system for critical events that negatively impact the health, safety or welfare of members.

Participating providers should:

- Identify an adverse incident. Some examples include, death, wrong surgical procedure, wrong site or wrong patient, surgical procedure to remove foreign objects remaining from a surgical procedure.
- Report the adverse incident to the appropriate entity (police, adult protective services, etc.).
- Call 911 if the member is in immediate danger.
- Report the adverse incident to the health plan and Department of Children and Family Services (DCFS) within 24 hours of identifying the incident.
- Report suspected abuse, neglect and exploitation of a member immediately in accordance with s.39-201 and Chapter 415, F.S.
- Complete the AHCA Critical Incident Report located in the AHCA Medicaid website or filling out the report below and submitting it to Humana's risk management team within 48 hours at: **RiskManagementAdministration@humana.com**.
- Or call the risk management department toll free at **855-281-6067.**

Critical Incident Report

Member rights and responsibilities

Care managers provide members with the following information at the time of enrollment and annually.

Members have the right to:

- Be free from all forms of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion.
- Request and receive a copy of his or her medical records and request that they be amended or corrected, as per rules set forth in 45 CFR parts 160 and 164 subparts A and E, and as specified in 45 CFR § 164.524 and 164.526.

Members also have the right:

- To be fully informed in advance of all care and treatment to be provided by the service provider, changes in care or treatment and to receive a copy of their plan of care if they request.
- To be fully informed of services available from the service provider and how to access care.
- To be fully informed by a physician of health status, unless medically contraindicated.
- To be afforded the opportunity to participate in the development of the care plan and to refuse treatment without retribution, while being fully informed of the possible medical consequences of refusal.
- To be assured of the confidentiality of records and to approve or refuse the release of information not authorized by law.
- To be treated with consideration, respect, full recognition of dignity and individuality, including privacy in treatment and in care for personal needs; to have property treated with respect.
- To file a grievance without fear of discrimination or reprisal from the service provider.
- To be informed of the state hotline number with hours of operation and purpose for obtaining information on home health agencies.
- To be assured that qualified personnel will present proper identification at the time of a visit.

- To be served without regard to race, color, creed, sex, age, national origin, ancestry or handicap/disability.
- To be advised — before care is initiated — of the cost of services and the extent to which payment may be required by the patient.
- To receive home and community-based services in a home-like environment and participate in their communities regardless of their living arrangements.
- To direct their care with their own staff and/or providers.

Members have a responsibility:

- To provide accurate and complete medical and health history information as they understand it.
- To participate with the plan of treatment, when possible, and make available an informal caregiver to assume primary care, as appropriate.
- To have a PCP who will provide orders (as required) for skilled home-care treatments and services.
- To inform the service provider about changes in health status, medications or treatments.
- To inform the agency of any change in financial status that may affect reimbursement for home care.
- To have a plan for management of emergencies and to access the plan, if necessary for safety.
- To inform the service provider of the presence of advance directives and provide copies, as appropriate.
- To accept services of service provider staff, without regard to race, creed, color, religion, national origin, handicap, sex or age.
- To report fraud, abuse and overpayment.
- To file a report of suspected fraud and/or abuse in Florida Medicaid:
    - Call the Consumer Complaint Hotline toll free at **888-419-3456.**
    - Call the Florida general hotline at **866-966-7226**.
    - Call the Special Investigations hotline at **877-217-9717**.
    - Complete a Medicaid fraud and abuse complaint form, which is available online at: **apps.ahca.myflorida.com/mpi-complaintform/**

If a member reports suspected fraud and the report results in a fine, penalty or forfeiture of property from a doctor or other healthcare provider, the member may be eligible for a reward through the Attorney General's Fraud Rewards Program. The reward may be up to 25% of the amount recovered, or a maximum of $500,000 per case (Section 409.9203, Florida statutes). Individuals can talk to the Attorney General's Office about keeping their identity confidential and protected by calling toll free at **866-966-7226** or **850-414-3990**.

Provider responsibilities

The provider contracting department has designed this handbook to assist network providers with an overview of our operational policies and procedures. As a participating provider, you and your staff will have a dedicated provider contracting representative who will be a key contact.

Provider contracting representatives are responsible for ensuring services are available to our members by obtaining contracts and by providing ongoing community and provider training and education about the Humana Healthy Horizons in Florida LTC plan. They also assist our network providers in understanding the terms of our contract and help resolve problems they may encounter.

You are encouraged to contact your provider contracting representative when you have questions, comments or concerns. To locate your local provider contracting representative, please call the provider hotline at **888-998-7735**.

Credentialing committee

The Credentials Committee is overseen by a Humana Chief Medical Officer (CMO) and is responsible for making determinations for all credentialing and recredentialing decisions. The credentials committee meets monthly and is comprised of participating providers in both primary care and specialty disciplines, including behavioral health, pharmacy and mid-level practitioners. The credentialing committee has the responsibility to establish and adopt, as necessary, criteria for provider participation and termination. The committee also directs credentialing procedures, including provider participation, denial

and termination. Failure of an applicant to adequately respond to a request for assistance may result in termination of the application process.

Initial credentialing

Providers seeking participation with the Humana Healthy Horizons in Florida Comprehensive Plan must complete an application with required documentation and a signed contract. It is required that all providers maintain active status with licensure and insurance coverage and provide proper documentation annually as documents expire. It is required that Humana be immediately notified of changes in a provider's licensure, status of insurance coverage, disciplinary actions and/or ownership.

Humana Healthy Horizons in Florida LTC plan's credentialing review includes, but is not limited to, the following criteria:

- Completion of a signed and dated application, signature not more than 180 days
- Copy of current provider's medical license, or occupational or facility license as applicable to provider type, or authority to do business, including documentation of provider qualification as outlined by the governing agency
- No revocation, moratorium or suspension of license
- A satisfactory level II background check pursuant to guidelines for all treating providers not currently enrolled in Medicaid's fee-for-service program
- Employer Background Screening Affidavit of Compliance with 435.05(3) F.S.
- Medicaid ID number or Medicaid provider registration number for enrollment by state Medicaid program for compliance with data submission. (Humana will take the steps necessary to ensure that a provider's business is recognized by the state Medicaid program, including its enrollment broker, as a participating provider. It will also take the steps necessary to ensure that a provider's submission of encounter data is accepted by Florida's Medicaid Management Information System [MMIS] and/ or the state's encounter data warehouse.)
- Certificate of insurance
    - Proof of general liability, professional liability (as applicable)
    - Proof of workers' compensation (as applicable)
    - Humana Healthy Horizons in Florida Comprehensive Plan listed as notify agent or certificate holder on the certificate of insurance
- Licensure inspection/AHCA survey as applicable
- W-9 indicating taxpayer identification number
- Disclosure of Ownership Addendum
- NPI
- CLIA certification, as applicable
- Provider Abuse, Neglect & Exploitation Questionnaire

HCB Setting Assessments - National Network Operations/ Credentialing Operations will verify ALFs, Adult Family Care Homes (AFCHs), and Adult Day Home Cares (ADHC) meet the requirement of offering a home-like environment and community inclusion characteristics as defined by the State of Florida. AHCA prescribed HCB Setting Assessment Tool is located at: **https://ahca.myflorida.com/medicaid/home-and-community-based-settings-rule/hcb-settings-assessment-and-remediation-tools**

Other site visits will be performed as deemed necessary. When credentialing and recredentialing a nursing facility provider, Credentialing Operations will review the facility's performance using the following measures as provided on the federal CMS Nursing Home Compare website at: **medicare.gov/nursinghomecompare/**.

Recredentialing

Network providers, including practitioners, organizational and LTC providers, are recredentialed at least every three years. As part of the recredentialing process, Humana considers information regarding performance to include complaints and safety and quality issues collected through the quality improvement program. Additionally, information regarding adverse actions is collected from the NPDB, Medicare and Medicaid Sanctions, CMS Preclusion list, the HHS/OIG and GSA (formerly EPLS), and limitations on licensure. A notification will be sent to the provider for reverification of credentialing. All network providers must submit updated documents as they expire. Failure to provide updated documentation may delay payment. A provider's

agreement may be terminated at any time if it is determined the credentialing requirements are no longer being met or the provider fails to complete the recredentialing process.

Provider monitoring

Humana monitors provider sanctions, complaints, and quality issues between credentialing cycles, and ensures corrective actions are taken to address occurrences of poor quality. Ongoing monitoring and appropriate interventions including removal from the network, by collecting the following information and taking steps to remove providers upon identification or notification of the adverse action(s):

- Medicare and Medicaid sanctions and exclusions, including AHCA Public Record Search: **apps.ahca.myflorida.com/dm_web**
- List of Excluded Individuals and Entities (LEIE)/Office of Inspector General (OIG)
- Excluded Parties List System (EPLS)/System for Award Management (SAM)
- Sanctions or limitations on licensure
- Complaints
- Identified Adverse Events

Right to review and correct information

Practitioners have the right to review, upon request, information submitted to support his or her credentialing application to the Humana Credentialing department.

Humana keeps all submitted information locked and confidential. Access to electronic credentialing information is password protected and limited to staff that requires access for business purposes.

Practitioners have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the Credentialing department prior to presentation to the credentialing committee. If information obtained during the credentialing or recredentialing process varies substantially from the application, the practitioner is notified and given the opportunity to correct information prior to presentation to the credentialing committee.

Practitioners have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing department.

Right to Appeal Adverse Credentialing Determinations

Humana's Credentials Committee may deny a provider's request for participation based on credentialing criteria. The Credentials Committee must notify a provider of a denial that is based on credentialing criteria and provide the opportunity to request reconsideration of the decision within 30 days of the notification. Reconsideration opportunities are available to a provider if he or she is affected by an adverse determination. To submit a reconsideration request, the following steps apply:

- Mail a reconsideration request to the senior medical director.
- A reconsideration request must be in writing and include any additional supporting documentation.
- Send it to:
  Humana
  Attn: Jennifer Moncrief, M.D., Regional Medical Director
  101 E Main St.
  Louisville, KY 40202

Upon reconsideration, the Credentials Committee may affirm, modify or reverse its initial decision. Humana will notify the applicant, in writing, of the Credentials Committee's reconsideration decision within 60 days.

Reconsideration denials are final unless the decision is based on Quality criteria and the provider has the right to request a fair hearing. Practitioners who have been denied are eligible for reapply for network participation once they meet the minimum health plan's credentialing criteria.

Applying providers do not have appeal rights. However, they may submit additional documents to the address above for reconsideration by the credentialing committee.

NPI

NPI is a unique government-issued standard 10-digit identifier mandated by the HIPAA. Humana requires that participating providers comply with this mandate, as appropriate. Please refer to the CMS website at **CMS.gov** for additional information and assistance with applying for an NPI.

Florida Medicaid provider number

All providers must be eligible for participation in the Medicaid program. If a provider is currently suspended or involuntarily terminated from the Florida Medicaid program whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider.

All providers are required to have a unique Florida Medicaid provider number in accordance with the guidelines of the AHCA. Each provider is required to have a NPI in accordance with Section 1173 (b) of the Social Security Act, as enacted by Section 4707 (a) of the Balanced Budget Act of 1997.

To comply with reporting requirements, Humana submits an electronic data file representing its credentialed and contracted provider network each week.

Having the proper Medicaid enrollment is critical. Incorrect enrollment can affect the way a healthcare provider or provider group is identified by AHCA and its Choice Counselors, as well as how it is listed in Physician Finder, Humana's online provider directory.

- Indications of proper healthcare professional enrollment include:
- Active listing on the PML on the AHCA portal
- Listing that shows "enrollment" or "limited" in the enrollment-type column
- Active (A) listing in the current Medicaid Enrollment Status column
- Accurate NPI listing related to attending, billing, ordering, prescribing, referring and rendering providers (not applicable to atypical providers) affiliated with the correct Medicaid ID.
- Listing with all active service and/or billing locations, provider type and provider specialty codes associated with its respective NPI and Medicaid ID.
- Provider must bill with the information that is in the AHCA PML. If claims are received with provider information that does not match the applicable active PML record, claims may be: rejected, denied, or subject for recoupment if paid in error.

Please note that CMS defines atypical providers as providers that do not provide healthcare.

AHCA's Provider Enrollment area is available to assist physicians and healthcare professionals with enrollment issues, such as change of address, change of ownership and re-enrollment issues via the AHCA website at: **portal. flmmis.com/FLPublic/Provider_ProviderServices/ Provider_Enrollment/tabId/42/Default.aspx**.

Guidelines on how physicians and other healthcare professionals should enroll with Medicaid can be found in the Provider's Enrollment Policy, Chapter 2 General Handbook Reference, Chapter 2 at **ahca.myflorida.com/ medicaid/review/general/59G-1.060.pdf 59G-1.060.pdf** (**myflorida.com**) Provider Orientation and Education

Providers are expected to adhere to all training programs identified by the contract and Humana as compliance- based training. This includes agreement and assurance that all affiliated participating providers and staff members are trained on the identified compliance material.

As part of the training requirements, providers must complete annual compliance training on the following topics:

- Humana Healthy Horizons in Florida Provider Orientation Training
- Compliance and Fraud, Waste and Abuse
- Cultural Competency
- Health, Safety and Welfare (Abuse, Neglect and Exploitation)

All new providers will also receive Humana Healthy Horizons in Florida's Provider Orientation.

Providers must also complete annual required training on compliance and fraud, waste and abuse to ensure specific controls are in place for the prevention and detection of potential or suspected fraud and abuse as required by Sec. 6032 of the federal Deficit Reduction Act of 2005.

Your provider contracting representative is available to provide an initial orientation within 30 calendar days of completion of the credentialing process. This orientation reviews Humana Healthy Horizons in Florida Comprehensive Plan policies and procedures. These personalized meetings are scheduled at your convenience, including staff you would like to attend. Additional educational trainings can be scheduled any time by contacting your local provider contracting representative.

Notice obligation

The network provider is responsible for giving the appropriate notices as outlined in this Provider Handbook and under the terms of your contract with Humana.

Changes in your office — Notify your provider contracting representative immediately of changes in your office, such as:

- Physical address change
- Tax identification/billing address change (W-9 required)
- Demographic changes (e.g., telephone, fax, email or administrative staff changes)
- New patient indicator
- Name and ownership change (35-day notice)

This notification will ensure your information is properly listed in the provider directory and all payments made are properly reported to the Internal Revenue Service. Failure to comply with this section could lead to a delay in payments.

Providing covered services — In the event there are changes in your office that will affect your company's ability to provide services to Humana Healthy Horizons in Florida Comprehensive Plan members, please notify the provider contracting department immediately.

Provider directory

The provider directory is a listing of all participating network providers with the Humana Healthy Horizons in Florida LTC Plan. A copy of this document is available upon request from the provider contracting department. You also can access the provider directory on our website at **Humana.com/FLLTC**.

Participating agreement standards

By signing a Humana Comprehensive Plan contract, providers are required to comply with all applicable federal and state laws and licensing requirements. Providers are required to maintain back-up procedures for absent employees to ensure services are not interrupted. Humana may exercise its options to terminate a participating provider from the provider network with the appropriate notice.

Accessibility and availability

Humana has adopted service standards regarding the availability of participating provider services. All providers are expected to maintain these standards as outlined in your contract.

Accessibility monitoring — Compliance with the availability and accessibility standards are monitored regularly through random sampling, review of member concerns, and member satisfaction surveys to ensure members have reasonable access to providers and services.

Provider satisfaction survey

Humana conducts an annual provider satisfaction survey that includes questions to evaluate provider satisfaction with our services, such as claims, communications, utilization management and provider services. We encourage you to participate and respond to the survey as the results are analyzed and used to develop provider- related quality improvement initiatives.

Quality improvement requirements

Humana will monitor and evaluate provider quality and appropriateness of care and service delivery (or the failure to provide

care or deliver services) to members through:

Performance improvement projects (PIPs) —

Ongoing measurements and interventions, significant improvement to the quality of care and service delivery, sustained over time, in both clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction.

- **Medical record audits** — Medical record reviews to evaluate patterns of complaints regarding poor quality of service, poor quality outcomes and adherence to member record documentation standards.
- **Performance measures** — Data collected on patient outcomes as defined by the Healthcare Effectiveness Data and Information Set (HEDIS®) or otherwise defined by the agency.
- **Surveys** — Consumer Assessment of Health Plans Surveys (CAHPS®)
- **Peer review** — Reviews of provider's practice methods and patterns and appropriateness of care.

Standards for member records

- Include the member's identifying information, including name, member identification number, date of birth, gender and legal guardianship (if any);
- Include information relating to the member's use of tobacco, alcohol and drugs/substances;
- Include summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow-up;
- Reflect the primary language spoken by the member and any translation needs of the member;
- Identify members needing communication assistance in the delivery of healthcare services;
- Include copies of any completed consent or attestation form(s) used by the managed care plan or court order for prescribed psychotherapeutic medication for a child younger than 13;
- All member records shall contain documentation that the member was provided with written information concerning the member's rights regarding advance directives (written instructions for living will or power of attorney), including information on Chapter 765, F.S., and whether or not the member has executed an advance directive. (42 CFR 438.3(j)(3));
- Neither the managed care plan, nor any of its providers shall, as a condition of treatment, require the member to execute or waive an advance directive. (42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5)).

Termination of provider contract

Each provider has the right to terminate his/her contract with Humana Long-term Care Plan. You must submit your request in writing and provide 90 days of notice. All termination requests need to be mailed to:

Humana Long-term Care Plan
Attention: Provider Contracting Department
3401 SW 160th Ave.
Miramar, FL 33027

Out-of-network/noncontracted services

An out-of-network provider is a provider who is not directly contracted with the Humana Long-term Care Plan. The Humana Comprehensive Plan is not responsible for payment of services provided by an out-of-network provider without written prior authorization.

Non-contracted services are services not defined on Schedule B of your contract. Humana is not responsible for payment of non-contracted services. If you or your staff identifies a service that a member may require that is not listed in your contract, please contact the member's care manager to evaluate the member's needs and determine if the service can be authorized by Humana. If the care manager determines that the service should be authorized by Humana, the care manager will contact your local provider contracting representative to discuss adding an addendum to your contract.

Humana Comprehensive Plan is not responsible for payments of services ordered by a member from a participating provider, without written preauthorization from a Humana Comprehensive Plan care manager. Please contact the member's assigned care manager to request authorization prior to providing services.

Minority recruitment and retention plan

Humana makes every effort to recruit and retain providers of all ethnicities to support the cultural preferences of its members. Humana's provider networks are not closed to new provider participation barring provider willingness to accept contractual requirements, contractual rates and satisfy all credentialing and regulatory requirements. Humana reviews and accommodates all provider nomination requests, when appropriate, from both members and providers to ensure all providers are equally represented in Humana's provider network.

As part of this process, Humana collects and publishes spoken languages in our provider directories on Physician Finder. Please be sure to accurately indicate all languages spoken in your office(s) on your Humana recredentialing application and/or CAQH application or contact your provider relations representative to have updates made.

Native Americans

Humana does not impose enrollment fees, premiums or similar charges on Native Americans served by a Native American Healthcare provider; Native American health service, a Native American tribe, tribal organization or urban Indian organization; or through referral under contract health services, in accordance with the American Recovery and Reinvestment Act of 2009.

Community outreach and provider-based marketing activities

Providers need to be aware of and comply with the following requirements:

- Healthcare providers may display health-plan-specific materials in their own offices. Providers are permitted to make available and/or distribute Humana marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all managed care plans with which the provider participates. If a provider agrees to make available and/ or distribute Humana's marketing materials, it should do so knowing it must accept future requests from other managed care plans with which it participates. Providers also are permitted to display posters or other materials in common areas such as the provider's waiting room. Additionally, long-term care facilities are permitted to provide materials in admission packets announcing all managed care plan contractual relationships.
- Healthcare providers cannot orally or in writing compare benefits or provider networks among health plans, other than to confirm whether they participate in a health plan's network. If a provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.
- Healthcare providers may announce a new affiliation with a health plan through general advertising (e.g., radio, television, websites). Providers may give their patients a list of health plans with which they contract.
- Healthcare providers may co-sponsor events, such as health fairs and advertise with the health plan in indirect ways, such as television, radio, posters, flyers and print advertisements.
- Healthcare providers shall not furnish lists of their Medicaid patients to the health plan with which they contract, or any other entity, nor can providers furnish other health plans' membership lists to the health plan; nor can providers assist with health plan enrollment.
- For the health plan, healthcare providers may distribute information about non-health-plan specific healthcare services and the provision of health, welfare and social services by the state of Florida or local communities as long as inquiries from prospective members are referred to the member services section of the health plan or the agency's choice counselor/enrollment broker. Providers may refer their patients to other sources of information, such as the managed care plan, the enrollment broker or the local Medicaid Area Office. They also may share information with patients from the agency's website or CMS's website.

Providers may not:

- Offer marketing/appointment forms.
- Make phone calls or direct, urge or attempt to persuade recipients to enroll in the managed care plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of the managed care plan.
- Offer anything of value to induce recipients/members to select them as their provider.
- Offer inducements to persuade recipients to enroll in the managed care plan.

- Conduct health screenings as a marketing activity.
- Accept compensation directly or indirectly from the managed care plan for marketing activities.
- Distribute marketing materials within an exam room setting.
- Furnish to the managed care plan lists of their Medicaid patients or the membership of any managed care plan.

The use of the Humana Healthy Horizons in Florida Comprehensive Plan name requires written notice prior to use in television, radio, posters, flyers and print advertisement.

Provider responsibilities

The provider must adhere to the following responsibilities:

- Provide all services in a culturally competent manner, accommodate those with disabilities and do not discriminate against anyone based on his or her health status.
- Treat all members with respect and dignity; provide them with appropriate privacy and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release.
- Maintain a safe environment and comply with city, state and federal regulations concerning safety and public hygiene.
- Ensure accessibility and availability of services to members.
- Notify the plan if a member is unable to receive services from a provider within a 3 hour window, and another aide is not able to be found to render service resulting in missed services. Missed Services are to be notified to the plan's care coach and documented in EVV.
- Participate and cooperate in quality management, utilization review and continuing education with other similar programs to provide care in a responsible and cost-effective manner.
- Participate in and cooperate with grievance procedures when notified of a member complaint or grievance.
- Comply with all applicable federal and state laws regarding the confidentiality of member records.
- Maintain communication with the appropriate agencies to provide member care.
- Ensure enrollment or registration by state Medicaid program for compliance with data submission.
- Maintain an emergency response plan.
- In the event of a disaster, the provider shall activate their emergency response plan and participate with Humana Comprehensive Plan to ensure member safety as well as coordinate member care as appropriate.
- Providers contracted with the Humana Comprehensive Plan should refer to their contracts for complete information regarding providers' responsibilities and obligations. Failure to comply could result in contract termination.

Provider complaint system

For all inquiries, including complaints, please contact Humana customer service at **888-998-7735** or your provider contracting representative. Based on the type of issue or complaint, your inquiry will be reviewed by a Humana associate with the designated authority to resolve your issue or complaint.

A provider complaint may be filed using the following steps:

Verbal complaint

A customer service specialist (CSS) will receive the initial call and attempt to resolve any issues or concerns at the time of the call. If the provider requests to file a complaint, the CSS will log the details in the database immediately, document the verbal acknowledgement given to the provider and transfer the complaint to the provider complaint resolution team.

Upon receipt of a complaint not involving claims from the CSS, the provider complaint resolution team will thoroughly investigate each complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the plan's written policies and procedures. The provider complaint resolution team will contact the provider and/or provider's office to research and resolve the issue within 90 days of receipt. Every 15 days, a written status report will be sent to the provider until the issue is resolved. A written notice of the disposition and the basis of the resolution will be sent to the provider within three business days of resolution.

Written complaint

The provider will submit in writing to:

Humana Long-term Care Plan
ATTN: Provider Contracting – Provider Complaint
3401 SW 160th Ave.
Miramar, FL 33027

Electronic requests can be emailed to: **FLResolutionLTSS@humana.com**

Upon receipt of a complaint not involving claims from the Humana Provider Correspondence team, the provider complaint resolution team will thoroughly investigate each complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the plan's written policies and procedures. The provider complaint resolution team will contact the provider and/or provider's office to research and resolve the issue within 90 days of receipt. Humana will notify the provider via a written acknowledgement letter within 3 business days of receipt of the complaint. Every 15 days, a written status report will be sent to the provider until the issue is resolved. A written notice of the disposition and the basis of the resolution will be sent to the provider within three business days of resolution.

The provider has 45 calendar days to file a written complaint for issues that are not related to claims.

For provider complaints related to claims, the provider should follow the same process outlined above. Please note the time frames for filing a claims complaint or reconsideration are listed in the table below.

Claims complaint

Topic	Response
How may complaints be submitted?	**In writing to:** **Humana Long-term Care Plan** ATTN: Provider Contracting – Provider Complaint 3501 SW 160th Avenue Miramar, FL 33027-4695 **Electronic requests may be sent to:** **FLResolutionLTSS@humana.com** Or call **888-998-7735**
What is the timeframe for complaint submission?	**Claims-related:** • Within 90 days of the date of the final determination of the primary payer **Non-claims related:** • Within 45 days of the date the issue occurred
What communication can be expected?	**Written complaints:** • Acknowledgement letter, within three business days of receipt of the complaint • Status letters, sent on the 15th day and every 15 days until resolved • Disposition letter, within three business days of resolution **Verbal complaints:** • Verbal acknowledgement at the time of receipt of the call • Status letters, send on the 15th day and every 15 days until resolved • Disposition letter, within three business days of resolution
What is the resolution timeframe?	**Claims complaints:** • Within 60 days after the receipt of the complaint, unless the claim is under active review by a mediator, arbitrator or third-party dispute entity **Non-claims complaints:** • Within 90 days of receipt of the complaint

Topic	Response
What is the timeframe for overpayment claim submissions?	Provider shall report to Humana when it has received an overpayment within 60 days after the date on which the overpayment was identified, and must notify Humana in writing of the reason for the overpayment as required by 42 CFR 438.608(d)(2), to be mailed to: **Humana Healthcare Plans** P.O. Box 931655 Atlanta, GA 3331193-1655

Cultural competency

Participating providers are expected to provide services in a culturally competent manner, which includes, but is 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.

Humana recognizes cultural differences and the influence that race, ethnicity, language and socioeconomic status have on the healthcare experience and health outcomes. It is committed to developing strategies that eliminate health disparities and address gaps in care.

“Unequal treatment: Report of the Institute of Medicine on racial and ethnic disparities in healthcare (2002)” found racial differences in the type of care delivered across a wide range of healthcare settings and disease conditions, even when controlling for socioeconomic status factors such as income and insurance coverage. Annual national healthcare disparities reports from the Agency for Healthcare Research and Quality (AHRQ) confirm that these gaps persist in the American healthcare system.

Communication is paramount in delivering effective care. Mutual understanding may be difficult during cross- cultural interaction between patients and providers. Some disparities may be attributed to miscommunication between providers and patients, language barriers, cultural norms and beliefs and attitudes that determine health- care-seeking behaviors. Providers can address racial and ethnic gaps in healthcare with an awareness of cultural needs and improving communication with a growing number of diverse patients.

Humana offers a number of initiatives to deliver services to all members regardless of ethnicity, socioeconomic status, culture and primary language. These include language assistance services, race and ethnicity data collection and analysis, internal staff training and Spanish resources. Other initiatives give providers resources and materials, including tools from health-related organizations that support awareness of gaps in care and information on culturally competent care.

To request a paper copy of Humana’s Cultural Competency Plan, please contact Humana customer service at **800-4HUMANA (800-448-6262)** or call your provider contracting representative. The copy of Humana’s Cultural Competency Plan will be provided at no charge to the provider.

Fraud and abuse policy

Provider must incorporate a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse.

Physician understands and agrees to educate physician’s employees about the False Claims Act’s prohibition on submitting false or fraudulent claims for payment, penalties for false claims and statements, whistleblower protections and each person’s responsibility to prevent and detect fraud, waste and abuse.

Humana and AHCA should be notified immediately if a physician/provider or their office staff:

- Is aware of any physician/provider that may be billing inappropriately, e.g., falsifying diagnosis codes and/or CPT

codes, or billing for services not rendered;
- Is aware of a member intentionally permitting others to use his/her member ID card to obtain services or supplies from the plan or any authorized plan provider;
- Is suspicious that someone is using another member's ID card;
- Has evidence that a member knowingly provided fraudulent information on his/her enrollment form that materially affects the member's eligibility in the plan.

Providers may provide the above information via an anonymous phone call to Humana's Fraud Hotline at **800-614-4126**. All information will be kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Humana ensures no retaliation against callers because Humana has a zero- tolerance policy for retaliation or retribution against any person who reports suspected misconduct.

Providers can also call Humana at **888-998-7735** and AHCA at **888-419-3456**, option 5.

In addition, providers may use the following contacts:

Telephonic:
- Special Investigations Unit (SIU) Direct Line: **800-558-4444** ext. 8187 (8 a.m. – 5:30 p.m., Eastern time, Monday – Friday)
- Special Investigations Unit 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
- Web: **Ethicshelpline.com**

Claims/billing protocol and standards

Humana maintains and complies with HIPAA standards for the submission and adjudication of claims. This section will provide information regarding the submission and payment process. If you have questions or would like training regarding submitting claims, please contact your local provider contracting representative.

Claim submission

A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 CFR 447.45.

All claims should be submitted to the Humana Long-term Care Plan within six months from the date of service, discharge from an inpatient setting or the date that the provider was furnished with the correct name and address of the managed care plan. When the managed care plan is the secondary payer and the primary payer is an entity other than Medicare, the managed care plan shall require the provider to submit the claim to the managed care plan within 90 days after the final determination of the primary payer, in accordance with the Medicaid Provider General Handbook. When the managed care plan is the secondary payer and the primary payer is Medicare, the managed care plan shall require the provider to submit the claim to the managed care plan in accordance with timelines established in the Medicaid Provider General Handbook. The managed care plan shall not deny Medicare crossover claims solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three years. Humana Long-term Care Plan shall not deny claims submitted by a nonparticipating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds 365 days. Claims that are incomplete, illegible or missing identifiable information may delay payment or could result in a denial of payment. For more information on claim submission, please visit our website at **Humana.com**.

Electronic claims

Humana Healthy Horizons in Florida Comprehensive Plan can receive electronic claims submission. The acceptable formats include X12 5010 837 institutional, professional and dental formats. Humana Healthy Horizons in Florida Comprehensive Plan also allows for direct data entry (DDE) through **Availity.com**.

When filing an electronic claim, you will need to utilize the following payer ID: 61115 for long-term care claims.

For questions on how to enroll in electronic claims submissions, please contact:

- Email: **FLResolutionLTSS@humana.com**
- Phone: 888-998-7735
- Web: **Availity.com**

Paper claims

Paper claims should be submitted to the address listed on the back of the member's ID card or to the address listed below:

Humana Healthy Horizons in Florida Long-term Care Plan
Attn: Claims Department
P.O. Box 14732
Lexington, KY 40512-4732

Encounter data

For claim payment inquiries, complaints, or if there is a factual disagreement with a response, please contact Humana Healthy Horizons® in Florida customer service at 888-998-7735 or your provider contracting representative. You also can email questions to: **FLResolutionLTSS@humana.com**

Submit claim disputes to:

Humana Healthy Horizons in Florida Long-term Care Plan
ATTN: Provider Contracting – Provider Complaint
3401 SW 160th Ave.
Miramar, FL 33027

In addition to the claim payment provisions outlined in your provider agreement, Humana should reimburse providers for Medicare deductibles and coinsurance payments for Medicare dual-eligible members according to the lesser of the following:

- Rate negotiated with the provider; or
- Reimbursement amount as stipulated in Section 409.908 F.S.

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

Availity Essentials™	**availity.com**	**800-282-4548**
WayStar	**waystar.com**	**877-494-7633**
Trizetto	**trizetto.com**	**800-556-2231**
McKesson	**mckesson.com**	**800-782-1334**
Change Healthcare	**capario.com**	**800-792-5256**
SSI Group	**thessigroup.com**	**800-881-2739**

AHCA requires 100% encounter submissions:

- 95% must pass through state system
- Necessitates appropriate provider registration and documentation
- Fee-for-service and capitated providers included

Encounters and claims identify members who have received services:

- Decreases the need for medical record review during HEDIS reviews
- Will be critical for future world of Medicaid Risk Adjustment
- Helps identify members receiving preventive screenings – decreases members appearing in gap reports

Sanctions for noncompliance can include liquidated damages and even enrollment freezes.

Payments due as a result of covered services rendered to Medicaid members shall be made by Humana on or before 90 calendar days, or such lesser time as may be contracted for between the parties, after all properly documented invoices and/or claims, and any documentation necessary for Humana to process such claims, have been received by Humana and in accordance with the reimbursement terms and conditions of the agreement and payment rates identified in Exhibit A, which is attached hereto and incorporated by reference.

Humana provider claim payments shall be 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, reimbursement amount and identification of Humana.

Humana shall make no payment, directly or indirectly, to a physician as an inducement to reduce or limit medically necessary services to a member. If Humana operates a physician incentive plan, it shall not provide incentives, monetary or otherwise, for the withholding of medically necessary care.

Humana shall assume full responsibility for collections in the event of third-party liability.

Common submission errors and how to avoid them

Common rejection or denial reasons:

1. Patient not found
2. Insured subscriber not found
3. Patient birthdate on the claim does not match that found in our database
4. Missing or incorrect information
    a. Providers submitting with incorrect NPI/ZIP code/ taxonomy/address/NPI type
    b. Missing NPI/ZIP code/taxonomy
    c. Providers submitting encounters with zero-dollar value
5. Invalid HCPCS code submitted
6. No authorization or referral found

How to avoid these errors:

1. Confirm that patient information received and submitted is accurate and correct.
2. Ensure that all required claim form fields are complete and accurate.
3. Obtain proper authorizations and/or referrals for services rendered.
4. Confirm provider information (information registered with AHCA).
5. Ensure billed amounts are not zero dollar. Must submit billed charges.

Timely filing

Providers are required to file timely claims/encounters for all services rendered to Medicaid members.

Providers shall submit to Humana Healthy Horizons in Florida all claims, and if capitated shall submit encounter data, for services rendered to comprehensive plan members in accordance with the terms and conditions in the AHCA contract. Notwithstanding anything to the contrary in the agreement, provider or subcontractor agrees to submit such claims within 180 days from the date of service, or encounter data, as applicable, to Humana Healthy Horizons in Florida within 30 days from the date of service.

The encounter data submission standards required to support encounter data collection and submission are defined by the agency in the Medicaid companion guides, pharmacy payer specifications and this section. In addition, the agency will post encounter data reporting requirements on the following website: **portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_CompanionGuides/tabId/62/Default.aspx**

Claims overpayments

Provider shall report to Humana when all claim overpayments for services rendered to Comprehensive managed care plan members in accordance with the terms and condition in the AHCA contract that have been received. Notwithstanding anything to the contrary in the agreement, provider or subcontractor agree to submit such claims within 60 days after the date on which the overpayment was identified, and to notify Humana in writing the reason for the overpayment as required by 42 CFR 438.608(d)(2). To be mailed to:

Humana Healthcare Plans
P.O. Box 931655
Atlanta, GA 31193-1655 Payment Suspension

Humana shall pay nursing facility providers in compliance with 42 CFR 488.417 and enforce any denial of payment for new admissions (DPNA) issued by the Centers for Medicare & Medicaid Services.

Electronic remittance advice (ERA) and electronic funds transfer (EFT)

Providers may register to receive their Humana ERA and payments/EFT and get paid up to seven days faster. If providers enroll on Availity.com and elect EFT, electronic funds will be utilized.

- Providers can sign up for EFT via Availity.com.
- Email questions to: **FLResolutionLTSS@humana.com**

Crossover claims

Effective Oct. 1, 2016, providers no longer need to send Medicare crossover claims for dually eligible recipients directly to Humana. Under this initiative, providers only need to submit their claims once to CMS for processing and are no longer required to submit secondary claims to Humana. This means CMS will automatically forward claims for members who are dually eligible for both Medicare and Medicaid coverage.

Please note: If a provider submits a claim for a dually eligible member that CMS has already forwarded to Humana, Humana will deny the provider-submitted claim as a duplicate claim.

Incentive plans

Upon request, the physician agrees to disclose to Humana within a reasonable timeframe not to exceed 30 days, or such lesser period of time required for Humana to comply with all applicable state and federal laws, rules and regulations, from such request, all of the terms and conditions of any payment arrangement that constitutes a physician incentive plan as defined by CMS and/or any state or federal law, between physician and other physicians. Such disclosure shall be in the form of a certification, or other form as required by CMS and/or AHCA, by the physician and shall contain information necessary for Humana to comply with applicable state and federal laws, rules and regulations and as requested by Humana.

Within 35 days of a request by AHCA or DHHS, physician shall disclose physician's ownership; any significant business transactions between physician and any wholly owned supplier or subcontractor during the five-year period ending on the date of the request; and the identity of any owner, agent or managing employee of the physician who has been convicted of a crime relating to any program under Medicare, Medicaid or the Title XX services program.

ALF providers

Room and board rate — Members are responsible for paying the room and board rate (as indicated in the provider's contract), plus patient responsibility (as determined by the DCF). Prorated fees will be determined for members who do not reside in the community for a full month. Humana Comprehensive Plan will be responsible for payment using the following formula:

Contracted ALF rate - room and board rate - patient responsibility = Humana payment

The patient responsibility is subject to change based on the Notice of Case Action (NOCA) received by DCF or estimated member responsibility until the appropriate NOCA is completed. Humana Comprehensive Plan staff will complete routine audits to ensure patient responsibility is being collected by the facility.

The provider is required to notify Humana Comprehensive Plan within 24 hours of a member hospitalization or leave of absence from the community.

Bed-hold payments — Humana Comprehensive Plan provides services for bed hold when our member is not in your community. Refer to the member handbook for additional coverage information. Coverage exceptions include:

- Member loses Medicaid eligibility
- Member expires
- Member is placed in a skilled nursing facility for long- term care
- The community fails to notify Humana Comprehensive Plan within 24 hours of a hospitalization or leave of absence from the community

Prorated fees will be determined for members who reside in a facility for less than a full month.

Bed holds or stop payment begins the day the member leaves the facility. The facility will not be paid for the day of discharge unless the member is eligible for a bed hold. If the facility fails to notify Humana Comprehensive Plan of a member leaving the community within 24 hours of discharge, it will result in a forfeit of payment for the bed hold. The facility may not charge the member for Humana Long-term Care Plan's portion of their bill during this time.

SNF providers

Custodial care — All members requiring custodial care must be assessed and a determination must be made by Humana Comprehensive Plan that the member can no longer live in a less restrictive setting. Members who receive approval for placement in a contracted SNF for custodial care are required to pay the facility a patient responsibility based on their income, which is determined by the DCF.

Custodial care payments — The facility will be reimbursed by Humana Comprehensive Plan at the current Medicaid per-diem rate established with the state minus patient responsibility determined by the DCF.

Bed holds for SNF — Humana Comprehensive Plan pays to reserve a bed for a maximum number of days for each hospital stay. One day is defined as an overnight stay away from the nursing facility.

Refer to the member handbook for additional coverage information.

Bed holds for therapeutic beds — Humana Comprehensive Plan pays the skilled nursing facility to reserve a residence bed for a resident to go to a family- type setting for a maximum number of days per each state fiscal year. One day is defined as an overnight stay away from the skilled nursing facility. Refer to the member handbook for additional coverage information.

Bed holds for custodial care members — Humana Comprehensive Plan follows the same guidelines as Medicaid. If your facility is requesting payment for a bed hold on a Humana Comprehensive Plan member, please submit a copy of your census along with your claim for the timeframe in question.

Respite care payments— The facility will be reimbursed by Humana Comprehensive Plan at the current Medicaid per- diem rate established with the state. Respite claims should be submitted on a facility form (UB-04) with the 0101 Revenue code and the appropriate Respite HCPC code.

Home health providers

Services should not be billed in a date range format. Each service should be listed separately by date of service.

Payments and balance billing

Payments made by or processed through Humana Comprehensive Plan are in accordance with the terms of your agreement with Humana Long-term Care Plan. Providers may not balance bill members of Humana Comprehensive Plan for covered services as per your agreement with Humana Long-term Care Plan.

Claim inquiry

Providers are encouraged to contact the customer service department to inquire about the status of a claim, status of reconsideration or explanation of a denial. A customer service representative can be reached by calling **888-998-7735**. Hours of operation are 8 a.m. to 8 p.m., Monday through Friday. If you are calling after hours, please leave a message and a representative will return your call within one business day.

Claim denials

All denials include an explanation of denial and/or explanation of adjustment when applicable. Denial codes are subject to change and/or additional codes may be utilized. Please call the claims customer service department at **888-998-7735** with questions or concerns regarding a denial or partial denial of payment.

EVV

Beginning Dec. 1, 2019, Humana Medical Plan implemented the federal mandate that requires providers verify the delivery of home health services using an EVV platform. Humana Medical Plan works with HHAeXchange (HHAX) as its exclusive EVV platform for Humana Healthy Horizons® in Florida's long-term care members as part of Florida's SMMC program.

HHAX offers a free EVV system to home health and personal care providers that are not currently using their own EVV system. To begin the process, complete the questionnaire found at **hhaexchange.com/FL-LTC**. The questionnaire answers allow HHAeXchange to configure the agency's portal. Providers utilizing EVV must also sign up for Availity as the lifecycle of a claim is as follows: HHA Exchange/EVV Portal>Availity>Humana. If the agency has an existing EVV system, the agency must complete the questionnaire found at **hhaexchange.com/FL-LTC** and the HHAeXchange Integrations Team will coordinate with the agency to create an interface with your existing EVV system to process your EVV visits and claims.

HHAeXchange healthcare provider functions include:

- FREE Electronic Visit Verification (EVV) tools
- Open Model EDI Integration with 3rd Party EVV Vendors
- Real-time, two-way messaging with each MCO
- Electronically receive recipient demographics, authorizations and plans of care
- Pre-bill scrubbing to ensure clean claims and accelerate revenue cycle

To learn more, call HHAeXchange at **855-400-4429** or visit the HHA Exchange Website **hhaexchange.com/fl-smmc/**.

Formal grievances and appeals

The section below is taken from Humana Healthy Horizons in Florida's Member Grievance and Appeal procedure as set forth in the Humana Healthy Horizons in Florida Member Handbook. This information is provided to you so that you may assist Humana Healthy Horizons in Florida members in this process, should they request your assistance. Please contact your provider contracting representative should you have questions about this process.

Humana has representatives who handle all member grievances and appeals. A special set of records is kept with the reason, date and results. Humana keeps these records in its central office.

Filing a grievance or an appeal

If a member has questions or an issue, he or she may call Humana Healthy Horizons in Florida Member Services at **800-477-6931 (TTY: 711),** Monday – Friday, 8 a.m. through 8 p.m., Eastern time.

If a member is not happy with the answer he or she receives from customer service, a member can file a grievance or appeal. A member can call customer service to file a complaint, grievance or an appeal. If a member calls about a complaint and we are unable to resolve the complaint by the close of business the following day, we will automatically send it to our grievance process. If a member would like to file a complaint, grievance or appeal in writing, the member may send us a letter or obtain a form from our website or file verbally by calling customer service. A member also can request help from Humana to fill out the form.

All grievances or appeals will be considered. The member can have someone help during the process, whether it is a provider or someone he or she chooses.

The member has the right to continue services during the grievance or appeal process. If the member would like his/ her services to continue, the member must submit an appeal within 10 calendar days after the notice of action is mailed; or on or before the intended effective date of action, whichever is later. However, if the decision of the appeal is not in the member's favor, the member may have to pay for those services.

The grievance or appeal must have the following:

- Name, address, telephone number and ID number
- Facts and details of what actions were taken to correct the issue
- What action would resolve the grievance or appeal
- Signature
- Date

Grievance: The member has the right to submit a written or verbal grievance. The grievance process may take up to 90 days. However, Humana will resolve the member's grievance as quickly as his or her health condition requires. A letter telling the member the outcome of the grievance will go out within 90 days from the date Humana receives the request. The member can request a 14-day extension if needed. Humana also can request an extension if additional information is needed and is in the member's best interest. Humana will send the member a letter telling him or her about the extra time, what additional information is needed, and why it is in the member's best interest.

Florida Medicaid Grievance First-Level Review

Topic	Response
In what manner may the grievance be submitted?	Oral or written
What is the time frame to submit the grievance?	Unlimited
Is an appointment of representation (AOR) required?	Yes
Is an AOR required?	Yes
Is an acknowledgment of the grievance required?	Yes, within five business day of receipt
What is the resolution time frame?	No later than 90 calendar days of receipt

Appeal: A member must file the appeal either verbally or in writing within 60 calendar days of the date on the notice of adverse benefit determination. The date of the oral notice will be considered the date of receipt. Humana will resolve the appeal as quickly as the health condition requires. A letter telling the member the outcome of the appeal will go out within 30 days from the date Humana receives the request. The member can request a 14-day extension if needed. Humana can also request an extension if additional information is needed and is in the member's best interest. Humana will inform the member of any extra time needed to make a decision, what additional information is needed, and why it is in the member's best interest.

Florida Medicaid Appeal First-Level Review Determination

Topic	Response
In what manner may the appeal be submitted?	Oral or written
What is the time frame to submit the appeal?	Within 60 days from the date of the notice of adverse benefit determination
Is an AOR required?	Yes, within five business days of the appeal receipt
What is the decision notification method?	Written
What is the decision time frame?	Appeal determinations should be rendered as expeditiously as the member's health condition requires but no later than 30 calendar days from receipt, whether received orally or in writing.

Expedited process: The member has the right to make an expedited verbal or written appeal. If there is a problem that is putting the member's life or health in danger, the member or the member's legal spokesperson can file an "urgent" or "expedited" appeal. These appeals are handled within 48 hours. When making an appeal, the member or member's legal spokesperson needs to let Humana know that this is an "urgent" or "expedited" appeal. An expedited appeal may be made by calling Humana at **888-259-6779**. If it is determined that an expedited process is not required, it will go through the normal process.

Humana shall not discriminate against **Provider** or take punitive action against a **Provider** who requests an expedited resolution or supports a member's appeal, as required by 42 CFR 438.410(b).

Florida Medicaid Expedited Appeal First-Level Review

Topic	Response
In what manner may the appeal be submitted?	Oral or written
What is the time frame to submit the appeal?	Within 60 calendar days from the date of the notice of action
Is an AOR required?	Yes, except from the provider
Is an acknowledgment of the appeal required?	Yes, oral acknowledgment is required no later than 24 hours of receipt
What is the decision time frame?	As expeditiously as the member's health condition requires but not to exceed 48 hours after receipt, whether the request was submitted orally or in writing

Medicaid Fair Hearing: If a member is not happy with Humana's appeal decision, he or she can ask for a Medicaid Fair Hearing. A member may only seek a Medicaid Fair Hearing after exhausting Humana's internal appeal process. The member has 120 days from the date of the appeal resolution to request a Medicaid Fair Hearing.

The addresses and phone numbers for Medicaid Fair Hearings at the local Medicaid area offices can be found at: **https://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/PUBLIC%20MISC%20FILES/Florida%20Medicaid%20Contact%20Information%20Sheet.pdf**

They are as follows:

Agency for Healthcare Administration
Medicaid Hearing Unit
P.O. Box 60127
Fort Myers, FL 33906

Call toll free: **877-254-1055** Fax: **239-338-2642**

Email: **MedicaidHearingUnit@ahca.myflorida.com**

The member has the right to continue to receive benefits during a Medicaid Fair Hearing. He or she can request to continue to receive benefits by calling our customer service department at **800-477-6931** between 8 a.m. and 8 p.m. If the decision is not in the member's favor, he or she may have to pay for those benefits. The member has the right to review his or her case before and during the appeal process.

To send a grievance or appeal request in writing, the member may mail it to the following address:

Humana Healthy Horizons in Florida
P.O. Box 14546
Lexington, KY 40512-4546

If the member wishes to contact our Member Services department by phone, he or she may call **800-477-6931 (TTY: 711)**.

If the member cannot hear or has trouble talking, he or she may call **800-833-3301**. Member services department hours are 8 a.m. to 8 p.m., Eastern time, Monday through Friday.

If the member is calling after-hours, weekends or holidays for an urgent/expedited grievance or appeal, he or she will be asked to leave a voicemail and will receive a callback by the end of the following day by a specialized team to address the expedited grievance or appeal.

Humana Healthy Horizons in Florida Comprehensive Plan

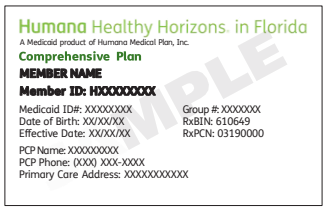
Introduction

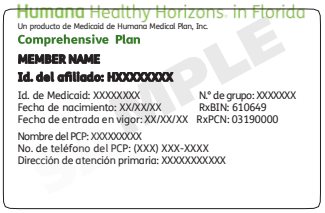
If you have a patient/member who is enrolled in both Humana Healthy Horizons in Florida's MMA plan and LTC plan, the plan name will be Humana Healthy Horizons in Florida Comprehensive.

Please refer to Section I – Humana Healthy Horizons in Florida Medical Plan for providers who are rendering medical services.

Please refer to Section II – Humana Healthy Horizons in Florida long-term care for providers who are rendering long- term-care services.

Humana Healthy Horizons in Florida Comprehensive Plan member ID samples





Appendix A: Delegated services, policies and procedures

Scope

The guidelines and responsibilities outlined in this appendix are applicable to all contracted Humana delegated entities (delegate). The policies in Humana's Provider Manual for Physicians, Hospitals and Other Healthcare Providers (manual) also apply to delegated entities.

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

Oversight

Although a health plan can delegate the authority to perform a function, it cannot delegate the responsibility or accountability for making sure that the function is performed in an appropriate and compliant manner.

Since Humana remains responsible for responsible for the performance and compliance of any function that is delegated, Humana provides oversight of the delegate.

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

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

The delegation process begins with Humana performing a pre-delegation audit prior to any function being delegated to a prospective entity, which will include evaluation of a prospective delegate's compliance and performance capacity. After approval and an executed delegation agreement, Humana will perform an annual audit. The pre-delegation and annual audits

will include a review and approval of the following applicable items of the prospective delegate:

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

Humana will continue to monitor all delegated entities through the collection of periodic reporting outlined within the delegation agreement. Humana will provide the templates and submission process for each report.

In addition, reporting requirements may change to comply with federal and state requirements or Humana standards. Any changes will be communicated to the delegate at such time.

Corrective action plans

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

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

Humana, legal, regulatory and accreditation requirements

The delegate will comply with the following requirements:

- Submit any material change in the performance of delegated functions to Humana for review and approval, prior to the effective date of the proposed changes.
- If required by state and/or federal law, rule or regulation, obtain and maintain, in good standing, a third-party administrator license/certificate and or a utilization review license or certification.
- Ensure that personnel who carry out the delegated services have appropriate training, licensure and/or certification.
- Adhere to Humana's record retention policy for all delegated function documents, which is 10 years (the same as the CMS requirement).
- Agree to not have a more stringent preauthorization and notification list than Humana's, which is posted on Humana.com.
- Follow Humana's Part B Step Therapy policy.
- Comply with requirements to issue member denial and approval letters in the member's preferred language if required by state laws, rules or regulations.

Sub-delegation

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

In addition, Humana must notify CMS within 30 days of the contract signature date of any location outside of the United States or a U.S. territory that receives, processes, transfers, stores or accesses Medicare beneficiary protected health information in oral, written or electronic form.

Note: Certain states may prohibit Medicaid protected health information from leaving the United States or U.S. territory.

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

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

The delegate is responsible for providing adequate oversight of the subcontractor and any other downstream entities.

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

Delegate agrees to monitor the subcontractor for federal and state government program exclusions on a monthly basis for Medicare and Medicaid providers and will maintain such records for monitoring activities. If delegate finds that a provider, subcontractor or employee is excluded from any Federal and/or state government program, they will be removed from

providing direct or indirect services for Humana members immediately.

Appeals and grievances

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

- Forward member appeals/grievances to Humana within one business day. Forward all expedited appeals immediately upon notification/receipt.
    - FL MCD MMA - Telephone: **800-477-6931** Fax: **800-949-2961**.
    - FL MCD LTSS - Telephone: **888-998-7732** Fax: **800-949-2961**.
- When faxing, delegate will provide the following information: date and time of receipt, member information, summary of the appeal or grievance, all denial information, if applicable, and summary of any actions taken, if applicable.
- Promptly effectuate the appeal decision as rendered by Humana and support any requests received from Humana in an expedited manner.
- Delegate will handle all participating physician, provider, hospital and other healthcare professional provider claim payment and payment denial disputes. Humana will handle all non-participating physician, practitioner, hospital and other healthcare professional provider claim payment and payment denial disputes or requests for reconsiderations.

UM delegation

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

UM activities and responsibilities

Delegate is to conduct the following functions regarding initial standard and expedited/urgent determinations:

- Perform preadmission review and authorization, including medical necessity determinations based on approved criteria, specific benefits and member eligibility.
- In full-risk arrangements, Humana performs this function when review decisions by delegate are not timely, are contrary to medical necessity criteria and/or when Humana must resolve a disagreement between delegate, providers and member. In some local health plans, Humana may assume total responsibility for this function.
- For concurrent review activities relevant to inpatient and SNF stays, delegate should:
    - Provide on-site or telephone review for continued stay assessment using approved criteria.
    - Identify potential quality-of-care concerns, including hospital reportable incidents, including, but not limited to, sentinel events and never events, and notification to the local health plan for review within 24 hours
    - of identification or per contract. Humana does not delegate quality-of-care determinations.
    - Provide continued stay determinations
    - Perform discharge planning and retrospective review activities.
- Perform, manage and monitor the referral process for outpatient/ambulatory care. Determine the appropriateness of each referral to specialists, therapists, etc., as it relates to medical necessity.

Delegate is also responsible for conducting retrospective reviews for outpatient/ambulatory care.

- Notify member, facility and provider of decision on initial determination using Humana- or state-approved letter templates.
- Determine the PAL that delegate will utilize for utilization management review.
    - If the delegate is performing both utilization management and claims payment on Humana's behalf, the delegate may utilize Humana's PAL or develop their own PAL. However, if the Delegate is only performing utilization management, the delegate must utilize Humana's PAL.
    - If the delegate utilizes their own PAL listing, it may not be more stringent than Humana's PAL.
- For all determinations, maintain log and submit as required by regulatory and accreditation organization

requirements. Humana retains the right to make the final decision regardless of contract type.
- Maintain documentation of pertinent clinical information gathered to support the decision.
- Maintain member denial files, including all supporting documentation; identify potential quality-of-care concerns and notify Humana within 24 hours of identifying such cases. Humana does not delegate quality-of-care determinations.
- Understand that denial files and all supporting documentation are Humana's property. Should the contract between the delegate and Humana be dissolved for any reason, the delegate is expected to make available to Humana either the original or quality copies of all denial files for Humana members.
- Perform UM activities for out-of-service areas and out- of-network providers as dictated by contract.
- Provide applicable UM reporting requirements outlined within the contract and related addenda or attachments. Humana will provide the template and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana standards. Any changes will be communicated to the delegate at such time.

Population health management (PHM) delegation

Delegation of PHM must include:

Complex case management (CCM): CCM is coordination of care and services provided to members who have 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.

Delegate should provide applicable PHM reports as outlined within the contract and related addenda or attachments. Humana will provide the template and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana standards. Any changes will be communicated to the delegate at such time.

Claims delegation

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

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

Claims performance requirements: All delegates performing claims processing functions must comply with all state and federal regulatory requirements.

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

- Delegate must accurately process at least 95% of all delegated claims according to Humana requirements and in accordance with state and federal laws, rules and regulations and/or any regulatory or accrediting entity to whom Humana is subject.
- Delegate must process all claims in accordance with state and federal prompt pay requirements to which Humana is subject to.
- Delegate must pay any and all interest amounts on claims in accordance with applicable state and federal requirements.
- Delegate must maintain an accuracy rate of 99% of total dollars paid, for any given calendar month.

- In the event the delegate is responsible for the processing and payment of claims for services rendered to any Humana Medicare Advantage or Medicaid members, delegate must comply with and meet the rules and requirements for the processing of Medicare Advantage or Medicaid claims established or implemented by CMS or the state.
- Delegate should use and maintain a claims processing system that meets current legal, professional and regulatory requirements.
- Delegate shall submit claim/encounter data in the format defined in the Process Integration Attachment.
- Delegation shall use Humana's member letter templates for all member communications.
- Delegate should prints its name and logo on applicable written communications including letters or other documents related to adjudication or adjustment of member benefits and medical claims.
- Delegation should forward all nonparticipating reconsideration requests to Humana upon receipt.
    - Delegate should provide applicable claim reports as outlined within the contract and related addenda or attachments. Humana will provide the template and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana standards. Any changes will be communicated to the delegate at such time.
- Delegate shall provide a financial guarantee, acceptable to Humana, prior to implementation of any delegation of claims processing, such as a letter of credit, to ensure its continued financial solvency and ability to adjudicate and process claims. Delegate shall submit appropriate financial information upon request as proof of its continued financial solvency.
- Delegate shall retain and maintain legal, claims and encounter documents for the period of time and in the manner required by state and federal law or Humana, including without limitation HIPAA and/or any requirements of regulatory or accreditation organization to which Humana is subject, whether voluntarily or not.
- Delegate shall make available as requested by Humana all original files, records and documentation pertaining to Humana members, or copies thereof upon the termination of the performance of delegated functions and/or the expiration, nonrenewal or termination of the agreement, regardless of the cause.

Continuous quality improvement delegation

All delegates are expected to function within a framework of continuous quality improvement and cooperate with Humana's quality improvement program. Additionally, some MBHOs, or other entities, may be delegated for a formal quality improvement function. This includes the following:

- Select quantifiable standards, goals and benchmarks for each monitoring activity.
- Collect, analyze and discuss data for each monitoring activity. At a minimum, the delegate's Quality Improvement committee should discuss the data. Humana should approve data collection methods.
- Plan and implement corrective actions to improve performance.
- Re-measure to determine success of corrective action interventions.
- Cite quantifiable care and service improvements related to the tracking and trending of Humana member

Credentialing delegation

The delegate is to comply with Humana's credentialing and recredentialing requirements, all applicable state and federal laws, rules and regulations and accreditation organization requirements pertaining to credentialing and/or recredentialing. This includes maintaining a credentialing committee, a credentialing and recredentialing program, and all related policies, procedures and processes in compliance with these requirements.

Credentialing and Recredentialing Requirements The delegate is responsible for verifying the following elements within the prescribed time frames and maintained within the provider's credentialing file.

- Current, valid state license(s) to practice
- Current, valid DEA or CDS certificate, if applicable
- Board certification status, if applicable
- Education and training at initial credentialing if not board certified
- Five-year work history at initial credentialing
- Professional liability claims history

- National Practitioner Data Bank (NPDB)*
- State license sanctions, restrictions or limitation on scope of practice
- Medicare and Medicaid sanctions
    - DHHS OIG List of Excluded Individuals and Entities (LEIE) or NPDB query
- Verification of Medicare and Medicaid Eligibility*
    - GSA Excluded Parties Lists System (EPLS)/SAM, and
    - Any applicable state eligibility or exclusion list
- Medicare Opt Out*
- Clinical privileges*
- Current malpractice insurance coverage
- Collection of applications, reapplications and signed attestation that addresses:
    - Inability to perform the essential functions of the position,
    - Lack of present illegal drug use, History of loss of license and felony conviction,
    - History of loss or limitation of privileges or disciplinary activity,
    - Signed and dated attestation to the correctness and completeness,
    - Signed and dated consent form, and
    - State-mandated application, if applicable
- Performance monitoring at recredentialing:*
    - Information from quality improvement activities, and
    - Member complaints
- Site visits that are required by law to be completed as part of the initial or recredentialing file, if required by your state
- Credentials committee review/decision
- Practitioner appeal process

*Medicare and/or Medicaid Only

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

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

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 to Humana of all credentialing approvals and denials within 30 days of the final credentialing decision date. Delegate should, at a minimum, include the elements indicated below in credentialing reports to Humana:

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

LTC member rights and responsibilities

Member rights

LTC members have the right to:

- Receive services in a home-life environment regardless of where the member lives.
- Receive information about being involved in the member's community, setting personal goals and how the member can participate in that process.
- Be told where, when and how to get the service(s) needed.

Member responsibilities

LTC members have the responsibility to:

- To tell the case manager of the decision to disenroll from the LTC program.
- Agree to and participate in the annual face-to-face assessment, quarterly face-to-face visits and monthly telephone contact with the case manager.