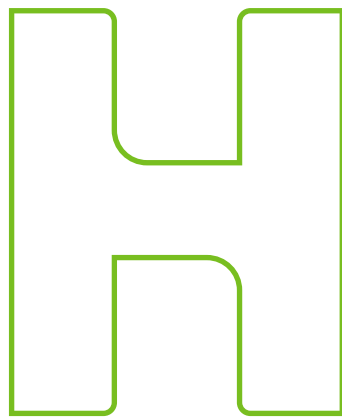
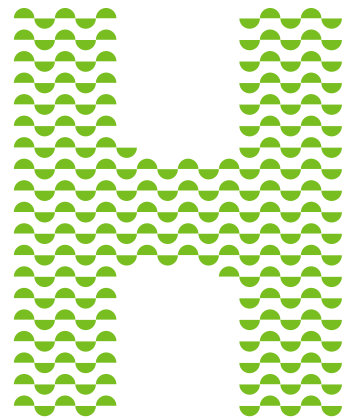


Humana

Healthy Horizons®
in Ohio

Provider Orientation and Training

Information for Medicaid Healthcare
Providers and Administrators 2025



Humana Healthy Horizons in Ohio is a Medicaid Product of Humana Health Plan of Ohio, Inc.



Provider topics

Welcome to Humana Healthy Horizons in Ohio	Member eligibility	Claims	Provider disputes system	Availity Essentials
Provider Network Management portal	Health information exchange and electronic health records	Member grievances and appeals	Clinical	Quality
Value-based programs	Healthcare provider training requirements	Fraud, waste and abuse	Web resources	Helpful numbers

Training topics are based on:

- Humana's contract with the Ohio Department of Medicaid (ODM)
- Humana's policies and procedures

Welcome to
Humana Healthy
Horizons in Ohio



Welcome to Humana Healthy Horizons in Ohio

Welcome and thank you for becoming a participating provider with Humana Healthy Horizons® in Ohio. We are a community-based health plan that serves Medicaid members throughout Ohio.

Our goal is to provide integrated care for our members, focusing on prevention and partnering with local providers to offer the services our members need to be healthy.



More information can be found at [Humana.com/HealthyOH](https://www.humana.com/HealthyOH) and by calling Provider Services at **877-856-5707**, Monday – Friday, 7 a.m. – 8 p.m., Eastern time.



Provider manual

The provider manual can be found at **[Humana.com/OHDocuments](https://www.humana.com/OHDocuments)**.

The manual is updated annually and is an extension of your provider agreement.

Additional details on all topics within this orientation can be found within the **[Humana Healthy Horizons in Ohio Provider Manual](#)**.



Member eligibility



Member eligibility and enrollment

Determination

ODM determines a member's eligibility and will provide eligibility information to Humana Healthy Horizons.

Newborn coverage

Newborn coverage starts on the date of birth when the newborn's mother is a member of a Humana Healthy Horizons plan.

Eligibility

If Humana Healthy Horizons members lose Medicaid eligibility but become eligible again within 90 days, they are automatically reenrolled in Humana Healthy Horizons and assigned to the same primary care provider (PCP), if possible.



You can verify member eligibility by signing in to Availity Essentials™ at www.availity.com and navigating to Patient Registration, then selecting Eligibility and Benefits Inquiry.

Claims



Claims submission process

The claims submission process is different for Humana Healthy Horizons than for other Humana business. For all payable claims:

- Electronic data interchange (EDI) must be submitted through the provider's EDI.
- Direct data entry (manual) claims and associated attachments must be submitted through [Availity Essentials](#).
- **Paper claim submissions are prohibited.**
- All Humana Healthy Horizons claims must include **Humana payer ID 61103**.

Please note: Humana's traditional fee-for-services payer ID (61101) cannot be used to submit Humana Healthy Horizons claims. Humana rejects all claims for all Humana Healthy Horizons-covered patients submitted in this manner.

Claims adjudication

- In accordance with 42 CFR 447.46, Humana Healthy Horizons:
 - Pays or denies 90% of all submitted clean claims within 21 calendar days of the date of receipt
 - Pays or denies 99% of clean claims within 60 calendar days of the date of receipt
 - Pays or denies 100% of all claims within 90 calendar days of receipt

Please note: Regardless of all established, mutually agreed alternative payment schedules described in the Provider Agreement between Humana Healthy Horizons and the network healthcare provider, Humana Healthy Horizons must abide by the time frames listed above.

If a provider and/or a provider's clearinghouse submits a Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 276 EDI transaction to Humana Healthy Horizons via Availity Essentials, then Humana Healthy Horizons responds with a complete HIPAA-compliant 277 EDI transaction within the required Council for Affordable Quality Healthcare (CAQH®) Committee on Operating Rules for Information Exchange time frames. These responses include HIPAA-compliant claim status category codes and claim status codes that provide information on all denied, paid or pended/suspended claims to the submitter.

Timely filing

- Providers will have 365 days to timely file a claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) rule 5160-1-19.
- Corrected claims must be submitted within 365 days of the date of service or 180 days of the date Medicare or another insurance plan paid the claim.
- Providers have 365 days from the date of service to file a written claim dispute or 60 calendar days after the payment, denial or partial denial of the timely claim submission, whichever is later.
- Claims timely filing and Healthcare Effectiveness Data and Information Set (HEDIS®):
 - Providers are required to file their claims/encounters in a timely manner for all services rendered to members. Timely filing is an essential component reflected in Humana Healthy Horizons' HEDIS reporting and can ultimately affect how a plan and its providers are measured in member preventive care and screening compliance.



Visit [Humana.com/OHDocuments](https://www.humana.com/OHDocuments) for more information on claims and payment processes.

Balance billing and missed appointments

Per the Humana Healthy Horizons in Ohio Provider Manual:

The provider, referral provider and subcontractor may not balance bill any member for services covered under the contract.

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

The Humana Healthy Horizons in Ohio Provider Manual and other provider communications can be found at [Humana.com/HealthyOH](https://www.humana.com/HealthyOH).



Visit [Humana.com/OHDocuments](https://www.humana.com/OHDocuments) for more information on claims and payment processes.

Provider disputes system



Provider claim dispute submissions

Provider claim disputes are any healthcare provider inquiries, complaints or requests for reconsiderations, ranging from general questions about a claim to a healthcare provider disagreement with the handling of a claim.

How to file:

Verbally

Call Provider Services:
877-856-5707,
Monday – Friday,
7 a.m. – 8 p.m.,
Eastern time.

In writing

Mail:
Humana Healthy Horizons in Ohio
Provider Disputes
P.O. Box 14601
Lexington, KY 40512-4601

Online

Complete claims status
application at
[Availity Essentials](#).

Availity Essentials



Working with Humana Healthy Horizons online—Availity Essentials

Humana Healthy Horizons' method for online transactions

- Submit claims
- Check eligibility and benefits
- View claim status (claim submission, updates and attachments)
- Submit/inquire on authorizations.
 - Authorization updates and attachments should be submitted via Availity Essentials.
- Confirm member primary language and special communication needs
- View remittance advice.
 - Electronic remittance advice (ERA) and electronic funds transfer (EFT) enrollment should be submitted via Availity.
- View member summaries
- Confirm/remedy overpayments
- Confirm/remedy appeals

Sign in to Availity at www.availity.com.

If you have not registered for Availity, you can do so here: **[Get Started - Register and Get Started with Availity Essentials](#)**

Help with Availity Essentials

Availity Client Services
Phone: **800-AVAILITY (282-4548)**

Humana Healthy Horizons in Ohio
Provider Services
Phone: **877-856-5707**, Monday – Friday,
7 a.m. – 8 p.m., Eastern time.

ERA/EFT enrollment

Enroll for electronic claim payments and remittance advice using Humana Healthy Horizons' ERA/EFT enrollment application.

The app enables you to:

- Receive payments via EFT into your choice of bank account(s)
- Receive ERA via your clearinghouse or download remits online via Availity Essentials
- Review previous ERA/EFT enrollment requests and check their status

Enroll by NPI or TIN

Humana offers enrollment by National Provider Identifier (NPI). This means you can have your organization's claim payments deposited in different bank accounts based on NPI. Or, if you prefer, you can have claim payments for an entire Tax Identification Number (TIN) deposited in a single bank account.

To access the ERA/EFT enrollment app:

1. Sign in to Availity Essentials and select Humana from the Payer Spaces menu.
2. From the Applications tab, select the ERA/EFT enrollment app.

Provider Network Management portal



Provider Network Management portal

ODM utilizes a **Provider Network Management (PNM)** module with a centralized credentialing feature to ease administrative burden.

Healthcare providers must utilize the PNM module to access the Medicaid Information Technology System (MITS) portal. Through the PNM link above, providers can:

- Submit and adjust fee-for-service claims
- Submit prior authorization (PA) requests
- Submit hospice applications
- Verify recipient eligibility

The link also allows providers to submit cost reports for managed service providers, hospitals and long-term care.

Creating an OH|ID and PNM account

Creating an OH|ID

- The OH|ID is an account created through the Innovate Ohio Platform that allows for a single ID to access systems for multiple state agencies throughout Ohio.
- An OH|ID is required to access the PNM module.
- You can create an OH|ID by going to: [Log In | OH|ID | Ohio's State Digital Identity Standard](#) and selecting “Create Account.”

Creating a PNM account

- Each individual user of PNM should have their own unique OH|ID account.
- The OH|ID will be used to log in to PNM and replaces any existing MITS login.
- [Creating an OH|ID Account for PNM Quick Reference Guide](#)

PNM—Source of Truth

Providers must update their ODM records in the PNM system. Per Ohio Administrative Code rule 5160-1-17.2(F):

“All providers with a signed Medicaid provider agreement agree to “inform ODM within thirty days of any changes including, but not limited to changes in licensure, certification, or registration status; ownership; specialty; additions, deletions, or replacements in group membership and hospital-based physician affiliations; and address, including all locations where services are rendered.”

Instructions for updating a provider file are available in PNM under “Learning.”

- **ODM PNM website**
- **Education and training resources**
- How to sign up for **PNM trainings through Absorb LMS**
- For PNM access and/or technical issues, please call the ODM Integrated Help Desk at **800-686-1516** or email **ihd@medicaid.ohio.gov** to obtain assistance.

Health information exchange and electronic health records



Health information exchange

Healthcare providers connected to health information exchanges (HIEs) can exchange protected health information, connect to inpatient and ambulatory electronic health records (EHRs), access care coordination information technology system records, and support secure messaging or electronic querying between providers, patients and the health plan. This includes, but is not limited to, using the HIEs for:

- Admission, discharge and transfer (ADT) data
- Closing referral loops for social determinants of health (SDOH)

Hospitals are required to provide ADT data to the Ohio HIE.

Information on the Ohio HIE can be found on the following website:

- [CliniSync](#)

Electronic health records (EHRs)

Advantages of EHRs:

EHRs and the ability to exchange health information electronically can help you provide higher quality and safer care for patients while creating tangible enhancements for your organization. EHRs help providers better manage care for patients and provide better healthcare by:

- Providing accurate, up-to-date and complete information about patients at the point of care
- Enabling quick access to patient records for more coordinated, efficient care
- Sharing electronic information securely with patients and other clinicians
- Helping providers more effectively diagnose patients, reduce Medicaid errors and provide safer care
- Improving patient and provider interaction and communication, as well as healthcare convenience
- Enabling safer, more reliable prescribing
- Promoting legible, complete documentation and accurate, streamlined coding and billing
- Enhancing privacy and security of patient data
- Helping providers improve productivity and work-life balance

Member grievances and appeals



Grievances and appeals

Grievances

Members or their authorized representatives can file a grievance at any time, orally or in writing, if they are dissatisfied with Humana Healthy Horizons or any aspect of their care.

Appeals

Members or their authorized representatives can file an oral or written appeal request within 60 calendar days of the date on the Notice of Action from us.

Member grievances and appeals contact information



Mail

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



Member Services

877-856-5702, Monday – Friday,
7 a.m. – 8 p.m., Eastern time

How providers can educate members about grievance and appeal rights

- Grievance and appeal information can be found in the Humana Healthy Horizons in Ohio Provider Manual located at [Humana.com/HealthyOH](https://www.humana.com/HealthyOH).
- If you have questions regarding Humana Healthy Horizons' grievance and appeal policy and procedures, you can call Provider Services at **877-856-5707**, Monday – Friday, 7 a.m. – 8 p.m., Eastern time, or ask your provider engagement representative.



Clinical



Health services and Utilization Management

Utilization Management (UM) helps maintain the quality and appropriateness of healthcare services provided to Humana Healthy Horizons members.

- Provides concurrent review and discharge planning
- Promotes effective level of care based on member's individual needs
- Refers to appropriate Humana Healthy Horizons programs

Prior authorizations

- The Ohio Medicaid Prior Authorization List (PAL) can be found online at [Humana.com/PAL](https://www.humana.com/pal).
- Humana Healthy Horizons has qualified UM review staff available by calling **877-856-5707**, Monday – Friday, 8 a.m. – 5 p.m., Eastern time, except for the following days: New Year's Day, Martin Luther King Jr. Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving and Christmas Day, to render UM decisions for providers.
- Humana Healthy Horizons allows providers to submit authorization requests for unplanned and/or emergency inpatient admissions the next business day, and the plan utilization review staff will review within the appropriate time frames for decision making.
- All UM review staff are appropriately qualified and licensed, with subject matter experts who review and make PA decisions for specialty services (e.g., services for substance use disorders, durable medical equipment).

Prior authorization submission

Availity Essentials will serve as the centralized location for provider submissions of PA requests for all services.

Healthcare providers must submit all PA requests, including provider-administered drug requests and associated attachments, through Availity Essentials via one of the following methods:

Practice management system: PA submissions sent from a provider's practice management system must use Humana's specific Humana Healthy Horizons in Ohio payer ID 61103 for Humana Healthy Horizons members.

Direct entry into Availity Essentials: After signing in to your Availity Essentials account, please select the following payer descriptions from the dropdown menu in Availity Essentials:

- Humana (medical)
- Humana behavioral health (BH)

Continuity of care

The managed care entity (MCE) Humana Healthy Horizons must allow the member's new to the plan up to 90 days to receive services from in- and out-of-network healthcare providers or if: Humana Healthy Horizons must allow up to 90 days to receive services from in- and out-of-network healthcare providers if the member is new to the plan or if:

- Humana Healthy Horizons confirms that the Group VIII-Expansion member currently receives care in a nursing facility on the effective date of enrollment with Humana Healthy Horizons.
- The member is pregnant and in the third trimester of pregnancy.
- A member's provider is terminated from the plan's network.

Transition of prior authorizations

If the member secures PA before the member's transition, Humana Healthy Horizons must honor the PA through the expiration of the authorization, regardless of whether the authorized or treating provider is in or out of Humana Healthy Horizons' network.

Humana Healthy Horizons may conduct a medical necessity review for previously authorized services if the member's needs change and warrant a change in service. Humana Healthy Horizons renders an authorization decision pursuant to OAC rule 5160-26-03.1.

Humana Healthy Horizons may help the member access services through a network provider when any of the following occur:

- The member's condition stabilizes, and Humana Healthy Horizons can ensure no interruption to services.
- The members choose to change their current provider to a network provider.
- There are quality concerns identified with the previously authorized provider.
- The member needs assistance with previously approved and/or pre-certified scheduled inpatient or outpatient surgeries, pursuant to OAC rule 5160-2-40, or appropriate follow-up care.
- There are questions regarding organ, bone marrow or hematopoietic stem cell transplant coverage.

Access-to-care requirements

- Healthcare providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, even if the provider serves only Medicaid managed care members.
- Participating providers must have accessibility 24 hours a day, 7 days a week, when medically necessary. An after-hours PCP phone number must be available to members.



Please refer to the Humana Healthy Horizons in Ohio Provider Manual for information on required appointment access standards.

Behavioral health services

Humana Healthy Horizons recognizes the significance of BH needs to overall health for well-being and emphasizes a strengths-based approach, with fully integrated physical and BH care. Humana Healthy Horizons' overall BH system includes mental health, alcohol and substance use disorder treatment, and developmental disabilities services, with the following being eligible:

- **Adults:** all covered BH services
- **Child/adolescent:** all covered BH services for child/adolescent members not enrolled in the OhioRISE Plan

PA process for BH: Please refer to the prior authorization section of this presentation or in the Humana Healthy Horizons in Ohio Provider Manual at [Humana.com/OHDocuments](https://www.humana.com/OHDocuments).

Substance use disorder treatment

- Humana Healthy Horizons utilizes American Society of Addiction Medicine (ASAM) level-of-care criteria and does not add criteria when reviewing level of care for substance use disorder treatment provided in a community BH center or a hospital billing outpatient hospital BH services.
- When making medical necessity determinations for inpatient services for co-occurring BH and physical health conditions or for co-occurring substance use and mental health disorders, other clinical criteria (e.g., MCG[®] or InterQual[®]) in addition to ASAM criteria are used. If either ASAM or MCG/InterQual indicates the need for inpatient services, the services are then authorized.
- The adolescent ASAM level-of-care criteria is used for members younger than 21.

Social determinants of health

Humana Healthy Horizons realizes the impact of SDOH on each member's health and health outcomes. Humana Healthy Horizons has a range of actions in place to address these factors, including:

- Completing assessments made by Humana Healthy Horizons case managers, including identification of SDOH needs.
 - Referrals to community-based organizations are made based on identified needs.
- Utilizing a robust network of community-based organizations for member referrals throughout Ohio
- Providing a closed-loop referral platform available through Humana Healthy Horizons' secured provider portal.
 - The closed-loop referral platform allows providers and their staff to search for resources and make and track/manage referrals.
- Aggregating information through the closed-loop referral platform and the network of community-based organizations to identify the correct community-based organizations for Humana's membership and member preferences and corresponding opportunities for partnership



For more information on SDOH, please visit [Humana.com/HealthyOH](https://www.humana.com/HealthyOH).

Care management overview

Care management:

Humana Healthy Horizons manages and coordinates care for members with special healthcare needs who require ongoing care management/chronic condition management. Outreach frequency is determined by individual member needs, preferences and risk level.

Humana Healthy Horizons includes the following steps in its care management:

- Identifies members through referrals from on-site/telephonic UM nurses, PCPs, specialists, member self-referral, health needs assessments, predictive model algorithms, post-discharge assessments, etc.
- Obtains member's permission/agreement to participate
 - Members can opt out at any time.
- Completes a comprehensive assessment, incorporating physical and behavioral health as well as SDOH
- Identifies key people of member's multidisciplinary care team and engages the PCP.
- Creates an individualized comprehensive care plan with the member and works toward identified goals
- Makes the individualized care plan available to providers by contacting Humana Healthy Horizons



More information is available at [Humana.com/HealthyOH](https://www.humana.com/HealthyOH).

Care management participation and referrals

Care management programs include:

- Care management for low-risk members
- Care management for moderate-risk members
- Intensive care management for high-risk members
- Complex care management for complex members
- Transitional care management
- Chronic condition management
- Neonatal intensive care unit (NICU) case management
- Transplant care management
- A maternity program, HumanaBeginnings®

Providers can contact Humana Healthy Horizons to refer members needing care management assistance:

- Call **877-856-5702** Monday – Friday, 7 a.m. – 8 p.m., Eastern time.
- Email:
 - Complex Care Management:
OHMCDCareManagement@humana.com
 - Chronic Condition Management BH:
OHMCDCareManagement_BH@humana.com
 - HumanaBeginnings prenatal:
OHMCDMaternity@humana.com
 - SDOH needs and short-term member coordination/scheduling support:
OHMCDSDOH@humana.com

Member care plans and health risk assessments are viewable, with member consent, on Humana’s provider portal [Availity Essentials](#).

Quality



Quality improvement requirements

Humana Healthy Horizons monitors and evaluates provider quality and appropriateness of care and service delivery to members using the following methods:

- **Performance improvement projects (PIPs)**—ongoing measurements and interventions that demonstrate significant improvement in the quality of care and service delivery sustained over time, in both clinical and nonclinical care areas, that have a favorable effect on health outcomes and member satisfaction
- **Performance measures**—data collected on patient outcomes as defined by HEDIS-or otherwise defined by ODM
- **Surveys**—includes Consumer Assessment of Healthcare Providers and Systems (CAHPS®), provider satisfaction, BH surveys and special surveys that support quality/performance improvement initiatives
- **Peer review**—review of provider’s practice methods and patterns to determine appropriateness of care

External quality review organization

Ohio's Medicaid state agency retains an external quality review organization (EQRO) for an annual external and independent review of the quality, outcomes, timeliness of and access to services provided by Humana, including medical record reviews for Humana Healthy Horizons members. Participating healthcare providers are expected to partner with Humana Healthy Horizons on all EQRO activities.

- A provider's contract with Humana Healthy Horizons requires the provider to furnish member medical records to Humana Healthy Horizons for this purpose.
- EQRO reviews are a permitted disclosure of a member's personal health information, in accordance with HIPAA standards.

Quality Assurance and Performance Improvement requirements

It is a contractual requirement for providers to comply with Humana Healthy Horizons' Quality Assurance and Performance Improvement (QAPI) program, which includes providing member records for assessing quality of care and EQRO activities.

Healthcare providers can obtain a written QAPI program description by calling Provider Services at **877-856-5707**, Monday – Friday, 7 a.m. – 8 p.m., Eastern time. We welcome healthcare practitioners' input regarding our QAPI program.

- Providers also must allow Humana Healthy Horizons to use provider performance data.
- Our QAPI program effectiveness is evaluated annually.
- Information regarding the QAPI program is available upon request.

Clinical practice guidelines

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

- **Provider website**
- Provider manual updates
- Provider communications

The protocols:

- Incorporate relevant, evidence-based medical and behavioral health guidelines from recognized sources, such as professional medical associations, voluntary health organizations and National Institutes of Health (NIH) centers/institutes.
- Help providers make decisions regarding appropriate healthcare for specific clinical circumstances.

Value-based programs



Value-based programs overview

Humana Healthy Horizons is committed to fostering high-value care in the communities we serve. Humana Healthy Horizons participates in the Ohio Department of Medicaid's value-based program (VBP) models, including Comprehensive Primary Care (CPC) and CPC for Kids. To learn more about these programs, please email your provider engagement professional at [**OHMedicaidProviderRelations@humana.com**](mailto:OHMedicaidProviderRelations@humana.com) or visit [**ODM's special programs and initiatives website**](#).

In addition to ODM's VBP models, Humana Healthy Horizons network healthcare providers can participate in a variety of VBPs that allow them to earn financial incentives and rewards based on quality, cost and clinical outcomes. The programs are designed based on the healthcare provider's panel size and readiness, as well as participation in ODM's programs or other specific contracting arrangements. Program terms and metrics are reviewed annually and modified as appropriate. All earned performance-based payments are made in arrears to allow for reporting and data collection. To learn more about Humana Healthy Horizons' available VBP programs, please contact [**Provider Engagement**](#).

ODM VBP opportunities

What is Ohio CPC?

CPC is a patient-centered medical home program, in which a team-based care delivery model is led by a primary care practice that manages a patient's health needs.

The goal is to empower practices to deliver the best care possible to their patients by both improving quality of care and lowering costs. Most medical costs occur outside a primary care practice, but PCPs can guide many decisions that impact those broader costs, improving cost efficiency and care quality.

CPC practices may be eligible for 2 payment streams, in addition to existing payment arrangements with ODM and the Medicaid managed care plans:

- Per-member-per-month (PMPM) payment, to support activities required by the CPC program
- Shared savings payment, to reward practices for achieving total cost-of-care savings

Additionally, joining the CPC program gives practices access to data and reports that provide actionable, timely information needed to make better decisions about outreach, care and referrals.

Healthcare provider training requirements



Compliance training required

- The Centers for Medicare & Medicaid Services (CMS) and state Medicaid contracts mandate that all Humana Healthy Horizons contracted healthcare providers complete compliance trainings each year.
- You must complete the Medicaid compliance training if your organization has rendered or may render healthcare services for a Medicaid-eligible beneficiary who is a member of a Humana Healthy Horizons administered Medicaid plan in Ohio.
- To be considered compliant for this training, please complete a training attestation form 1 of the following ways:
 - **Manually**
 - **Availity Essentials**

Initial and ongoing provider training requirements

Healthcare providers receive ongoing education based on a variety of topics, including provider requirements, member care expectations, changes in policies and procedures, billing, and issues resolution processes.

Training is delivered via:

- Print communications (provider manual, newsletters, clinical and non-clinical educational materials)
- **Humana's provider website** and **Availity Essentials**
- In-person training (one-on-one, face-to-face, town hall meetings)
- Virtual training (webinars)
- Provider orientations
- Provider technical assistance

Additional training requirements

Humana Healthy Horizons requires contracted healthcare providers to complete additional annual compliance training on the following topics:

- General compliance, fraud, waste and abuse
- Cultural competency
- Health, safety and welfare (abuse, neglect and exploitation)
- Others, as required

These training materials can be found at Provider.humana.com/working-with-us/provider-compliance and www.availity.com.

Be sure to submit a completed Medicaid Partner Training Attestation form to document completion of training.

Fraud, waste and abuse



Fraud, waste and abuse reporting requirement and reporting options

Anyone who suspects or detects a fraud, waste and abuse (FWA) violation is required to report it either to the appropriate state agency or within their respective organization, which then must report it to Humana Healthy Horizons.

Contact Humana Healthy Horizons using the following methods:

- **Telephone:**
 - SIU Hotline: **800-614-4126** (24/7 access)
 - Ethics Help Line: **877-5-THE-KEY (584-3539)**
- **Email:** siureferrals@humana.com or ethics@humana.com
- **Web:** EthicsHelpline.com

All information will be kept confidential.

Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Also, Humana has a zero-tolerance policy for retaliation or retribution against all individuals who report suspected misconduct.

FWA reporting information

You can contact ODM by:

- Calling: **614-466-0722**
- **ODM's reporting suspected Medicaid fraud site**

Ohio Attorney General's Office Medicaid Fraud Control Unit (MFCU):

- Calling: **800-282-0515**
- **MFCU website**

Ohio Auditor of State:

- Calling: **866-FRAUD-OH (372-8364)**
- Emailing: **fraudohio@ohioauditor.gov**



False Claims Act

- The False Claims Act permits a person with knowledge of fraud against the U.S. government to file a lawsuit (plaintiff) on behalf of the government against the person or business that committed the fraud (defendant).
- Individuals who file such suits are known as “whistleblowers.” If the action is successful, the plaintiff is rewarded with a percentage of the recovery. Retaliation against individuals for investigating, filing or participating in a whistleblower action is prohibited.

Liability (31 U.S.C. § 3729(a)(1) and (a)(3)): Liability for the foregoing acts includes:

- A civil penalty of \$5,000–\$10,000
- 3 times the amount of damages the government sustains because of that act
- A person or company who violates the False Claims Act is also liable to the government.

Disallowed Actions (31 U.S.C. §§ 3729-3733)

Links to the previously mentioned provisions of this act are listed within Humana’s Compliance Policy for Contracted Health Care Providers and Business Partners, which is available at [Healthcare Fraud, Waste and Abuse - Humana](#).

Web resources



Provider website—public



Provider Website

- Answers to frequently asked questions
- Availity Essentials
- Behavioral and physical health clinical coverage policies
- Behavioral health toolkit
- Claims and payments
- Clinical practice guidelines
- Communications and network notices
- Documents and resources
- External medical review
- Join our network
- Optimization of pregnancy outcomes
- Pharmacy
- Pharmacy clinical coverage guidelines
- Prior authorization
- Provider network management
- Services for children
- Telehealth services
- Training materials



For questions about and assistance with [Humana.com](https://www.humana.com), please call Provider Services at **877-856-5707**, Monday – Friday, 7 a.m. – 8 p.m., Eastern time.

Provider orientation and training revisions

This Provider Orientation and Training document is reviewed and updated at least once a year. Orientation updates include, but are not limited to, the following:

- New or revised policies and procedures and administrative clinical practices
- Modifications to existing services
- New or amended Medicaid policies and procedures, including state and federal mandates

Updated versions of the Provider Orientation and Training document are posted on the Humana Healthy Horizons [training materials website](#).

Access the [Humana Healthy Horizons in Ohio Provider Manual](#).

Helpful numbers



24-hour Nurse Advice Line

Humana Healthy Horizons' 24-Hour Nurse Advice Line offers 24/7 access to health information and medical triage services to Humana Healthy Horizons members. Members can access this free service by calling **866-376-4827**.

The nurses who staff the hotline can:

- Assess symptoms, answer health-related questions, and make recommendations for the most appropriate treatment, clinical resources and care setting (e.g., home, virtual consultation, retail clinic, provider's office, urgent care, emergency room)
- Offer advice on urgent and nonurgent care
- Deliver health and wellness education, reminders, and resources
- Explain condition, procedure and treatment options
- Help deliver medication information, including drug interactions, appropriate use, and adherence benefits and strategies



Emergency and crisis behavioral health calls

Ohioans experiencing a mental health or addiction crisis, and their family members, can call, text or chat the **988** Suicide & Crisis Lifeline to reach a trained specialist who can offer help and support. The easy-to-remember, 3-digit number provides 24/7, free and confidential support to Ohioans in a behavioral health crisis. **988** is a direct connection to compassionate, accessible care and support for anyone experiencing mental health-related distress.

For more information about the **988** Suicide & Crisis Lifeline in Ohio, email 988ohio@mha.ohio.gov. If you or someone you know is in crisis, call, text or **chat**.

If the member calls Humana Healthy Horizons directly, we operate a 24/7 system to route emergent and crisis behavioral health calls directly to the Ohio Department of Mental Health and Addiction Services (OhioMHAS) statewide crisis line.

As needed, Humana Healthy Horizons collaborates with ODM and OhioMHAS to ensure the OhioMHAS statewide crisis line has access to mobile response and stabilization services providers to deploy when necessary.



Helpful numbers

Humana Healthy Horizons' provider interactive voice response line (IVR):
877-856-5707

- Prior authorization assistance for medical procedures, behavioral health and medications billed as medical claim
- Utilization Management
- Medical and behavioral health inquiries
- Care management and chronic condition management

Humana Healthy Horizons member IVR: **877-856-5702**

Humana Healthy Horizons Coordinated Services Program: **833-410-2496**

Humana
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