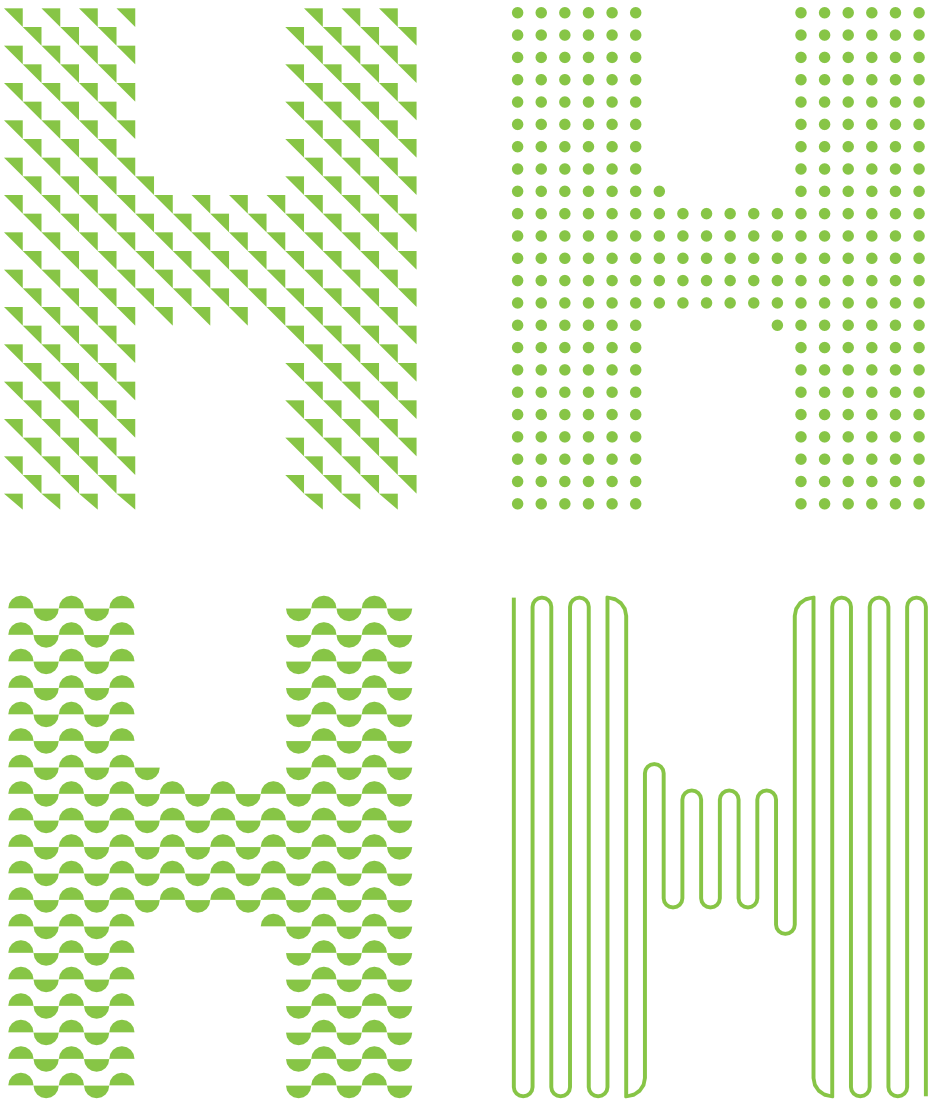

# 2024 Provider Manual

## ILLINOIS-HUMANA GOLD PLUS INTEGRATED MEDICARE-MEDICAID

Humana®

09305IL0224 (ILHLPEJEN)

# Table of contents

# Welcome

Thank you for your participation with Humana, where our goal is to provide quality services to Demonstration members. This provider manual is a contract extension designed to highlight key points related to Illinois Demonstration policies and procedures. Its goal is to be a guideline for facilitation that informs you and your staff:

- About the purpose that the Illinois Demonstration program is designed to serve
- What you can expect from Humana and Carelon, the Behavioral Health Network Provider
- What we need from you

The guidelines outlined in this appendix are designed to help you provide caring, responsive service to our Humana Gold Plus®-integrated members.

We look forward to a long and productive relationship with you and your staff. Should you need further assistance, please contact your network management consultant.

Sincerely,

Paul Maxwell
Vice President, Provider Development

# Section I – General Provider Information

## Program description

The Illinois-Humana Gold Plus Integrated Medicare-Medicaid Plan is a Demonstration designed to improve healthcare for dually eligible Illinois beneficiaries. Jointly administered by the Centers for Medicare & Medicaid Services (CMS) and the Illinois Department of Healthcare and Family Services (HFS), MMAI allows eligible Illinois beneficiaries to receive Medicare Parts A, B and D benefits and Medicaid benefits from a single Medicare-Medicaid Plan, or MMAI, plan.

By integrating and coordinating individuals' healthcare benefits, the Demonstration aims to:

- Improve quality and the beneficiary experience in accessing care;
- Promote person-centered care planning;
- Promote independence in the community;
- Rebalance long-term services and supports (LTSS) to strengthen and promote the community-based systems; and
- Eliminate cost shifting between Medicare and Medicaid

The following information is intended as an orientation and guideline for the provision of covered services to Humana members and features policies, procedures and general reference information including minimum standards of care that are required of Humana providers.

Humana may choose not to distribute this information via surface mail, but rather give a written notification to you that explains how to obtain it from a website. This notification would also detail how you can request a hard copy at no charge. It is kept up-to-date and in compliance with state and federal laws. This information serves as a reference source regarding Humana's covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all requirements of a government-sponsored contract are met.

As part of its agency contract to provide Demonstration services, Humana will comply with MMAI contract provisions and applicable MMAI-related agency rules that the state may implement to regulate plan administration.

**NOTE:** Manual Section I applies to all Demonstration providers. For additional details related to long-term services and supports providers, please see Section II of the manual. For additional details related to behavioral health providers, please see Section III.

## Covered services

### General services

Through its contracted providers, Humana is required to arrange for medically necessary services for each member. When providing covered services to plan members, the provider must adhere to applicable plan coverage provisions and all applicable state and federal laws.

### Out-of-network care for unavailable services

On notification of authorization from a referring provider, Humana will arrange out-of-network care if unable to provide necessary covered services or ensure the second opinion of a participating network provider.

### Value-added benefits

Value-added benefits are those offered by Humana and approved in writing by the state. Such services are included in the benefit summaries below. For additional information, providers can call the customer service number provided on the back of the Humana member's ID card.

**NOTE:** Humana's provider network also will arrange, as necessary, for specialty, LTSS and behavioral health care.

## Table 1-1 Covered plan services (general)

### $0 member copay

**Abdominal aortic aneurysm screening**

Humana will cover a one-time ultrasound screening for at-risk members. Humana covers this screening only if the member has certain risk factors and receives a referral from their physician, physician assistant, nurse practitioner or clinical nurse specialist.

**Acupuncture for chronic low back pain**

Humana will pay for up to 12 visits in 90 days for members who have chronic low back pain, defined as:

- Lasting 12 weeks or longer; not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease)
- Not associated with surgery and
- Not associated with pregnancy

Humana will pay for an additional eight sessions if the member shows improvement. The member may not get more than 20 acupuncture treatments each year. Acupuncture treatments must be stopped if there is no improvement.

**Alcohol misuse screening and counseling**

Humana covers one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.

If a member screens positive for alcohol misuse, Humana covers up to four brief, face-to-face counseling sessions each year (if member is able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.

**Ambulance services**

Covered ambulance services, whether for an emergency or non-emergency situation, include fixed-wing, rotary-wing and ground ambulance services. The ambulance will take the member to the nearest facility that can provide care.

The member's condition must be serious enough that other ways of getting to a place of care could risk the member's life or health. Ambulance services for other cases must be approved by Humana.

In cases that are not emergencies, Humana may pay for an ambulance. The member's condition must be serious enough that other ways of getting to a place of care could risk the member's life or health.

**Annual wellness visit**

Members who received Medicare Part B coverage for more than 12 months can get an annual checkup, in an effort to make or update a prevention plan based on the member's current risk factors.

**NOTE:** Members cannot have their first annual checkup within 12 months of their "Welcome to Medicare" preventive visit. Members are covered for annual checkups after having Part B coverage for 12 months. Members do not need to have had a "Welcome to Medicare" visit first.

**Behavioral health crisis services**

Humana is expanding services to include mobile crisis response (MCR) and crisis stabilization services. Expanded crisis services may be provided for up to 30 days following an MCR event to prevent additional behavioral health crises. To access MCR services, Humana members or concerned individuals should call the Crisis and Referral Entry Services (CARES) line, the state's crisis intake line, at 800-345-9049 (TTY: 866-794-0374). CARES will dispatch a local provider to the location of the Humana member in crisis. Humana will cover mobile crisis response and crisis stabilization services provided by:

- Community mental health centers (CMHCs) with state crisis certification
- Behavioral health clinics with state crisis certification

**Bone mass measurement**

Humana covers certain qualifying member procedures, including those procedures that reduce risk of osteoporosis or loss of bone mass. These procedures identify bone mass or assess bone quality. Humana covers the services once every 24 months, or more often if medically necessary. Humana also covers the cost of a doctor to review and comment on the results.

### Mammograms

Humana covers the following services:

- One baseline mammogram between the ages of 35 and 39
- One screening mammogram every 12 months for women 40 and older
- Clinical breast exams once every 24 months

### Cardiac rehabilitation services

Humana covers cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's referral. Humana also covers intensive cardiac rehabilitation programs.

### Cardiovascular disease risk reduction visit (heart disease therapy)

Humana covers one PCP visit per year to help lower heart disease risks. During this visit, the PCP may:

- Discuss aspirin use
- Check member blood pressure or
- Provide tips for healthy eating

### Cardiovascular disease testing

Humana covers blood tests to check for cardiovascular disease once every five years (60 months). These tests also check for heart defects due to high heart disease risk. Additional testing may be provided by the member's primary care provider, if medically necessary.

### Cervical and vaginal cancer screening

Humana covers Pap tests and pelvic exams once every 12 months.

### Chiropractic services

Humana covers adjustments of the spine to correct alignment.

### Colorectal cancer screening

Humana covers the following services:

- Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema.
- Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema.
- Screening fecal-occult blood tests for patients 45 years and older, once every 12 months. Multitarget stool DNA for patients 45 to 85 years of age once every three years who do not meet high-risk criteria..
- Blood-based biomarker tests for patients 45 to 85 years of age once every three years who do not meet high-risk criteria. Once every three years.
- Barium enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy.
- Barium enema as an alternative to flexible sigmoidoscopy for patients 45 years or older and who are not high-risk. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy.

As of Jan. 1, 2023, colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered, non-invasive stool-based colorectal cancer screening test resturns a positive result.

### Counseling to stop smoking or tobacco use

For tobacco-using members who show no signs or symptoms of tobacco-related disease, Humana covers:

- Two quit counseling attempts in a 12-month period as a free preventive service

For tobacco-using members diagnosed with a tobacco-related disease or who take medicine that may be affected by tobacco, Humana covers:

- Two quit counseling attempts within a 12-month period

For pregnant tobacco-using members, Humana covers:

- Three quit counseling attempts within a 12-month period

NOTE: Each counseling attempt includes up to four face-to-face visits

### Dental services

Humana covers the following dental services:

- Limited and comprehensive exams
- Restorations
- Dentures
- Extractions
- Sedation
- Dental emergencies
- Dental services necessary for the health of a pregnant woman prior to delivery of her baby

The following additional dental benefits are covered:

- One oral exam every six months
- One prophylaxis-cleaning every six months

### Depression screening

Humana covers one depression screening each year.

The screening must be conducted in a primary care setting that can give follow-up treatment and referrals.

### Diabetes screening

Humana covers this screening (includes fasting glucose tests) if the member has any of the following risk factors:

- High blood pressure (hypertension)
- History of abnormal cholesterol and triglyceride levels (dyslipidemia)
- Obesity
- History of high blood sugar (glucose)

Tests may be covered in some cases, such as if the member is overweight and has a family history of diabetes. Depending on the test results, the member may qualify for up to two diabetes screenings every 12 months.

### Diabetic self-management training, services and supplies

Humana covers the following services for all members who have diabetes (whether they use insulin or not):

- Supplies to monitor the member's blood glucose, including the following:
  - Blood glucose monitor and test strips
  - Lancet devices and lancets
  - Glucose-control solutions for checking the accuracy of test strips and monitors
- For members with diabetes who have severe diabetic foot disease, Humana will cover the following:
  - One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, or
  - One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)
- Humana will also cover fitting the therapeutic custom-molded shoes or depth shoes.
- Humana will cover training to help members manage their diabetes, in some cases.

### Emergency care

Emergency means services that are:

- Given by a provider trained to give emergency services, and
- Needed to treat a medical emergency

A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:

- Serious risk to the member's health or to that of the member's unborn child; or
- Serious harm to bodily functions; or
- Serious dysfunction of any bodily organ or part; or, in the case of a pregnant woman in active labor:
  - There is not enough time to safely transfer the member to another hospital before delivery, or
  - The transfer may pose a threat to the health or safety of the member or unborn child.

Emergency care coverage is provided worldwide.

**NOTE:** If a member receives emergency care from an out-of-network hospital and requires inpatient care after their condition has stabilized, they must return to an in-network hospital for continued care to be eligible for payment by Humana. Only plan approval permits a member to remain in the out-of-network hospital for inpatient care.

### Family planning services (prior authorization is required for infertility and genetic testing)

Members may receive family planning services from the provider (doctor, clinic, hospital, pharmacy or family planning office) of their choice.

Humana covers the following services:

- Family planning exam and medical treatment
- Family planning lab and diagnostic tests
- Family planning methods (birth control pills, patch, ring, intrauterine device (IUD), injections, implants)
- Prescribed family planning supplies (condom, sponge, foam, film, diaphragm, cap)
- Infertility diagnosis, counseling and related services
- Counseling and testing for sexually transmitted infections (STIs), acquired immunodeficiency syndrome (AIDS) and other human immunodeficiency virus (HIV)-related conditions
- Treatment for STIs
- Voluntary sterilization
  - Members must be 21 or older and sign a federal sterilization consent form.
  - At least 30 days (but not more than 180 days) must pass between the date a member signs the form and the date of surgery.
- Genetic counseling
- Folic acid supplements and prenatal vitamins ordered by prescription and dispensed by a pharmacy

Humana also covers other family planning services. However, members must use a provider in Humana's network for the following services:

- Treatment for medical conditions of infertility (this service does not include artificial ways to become pregnant)
- Fertility preservation services
- Treatment for AIDS and other HIV-related conditions
- Genetic testing

### Gender-affirming services

For members with a diagnosis of gender dysphoria, Humana covers gender-affirming services. Some screenings and services are subject to prior authorization and referral requirements.

### Health and wellness education programs

Humana provides the following services:

- Online and printed health education materials and tools
- Disease management programs
- Nutrition counseling

### Hearing services

Humana covers hearing and balance tests performed by the member's provider to assess medical treatment needs. The tests are covered as outpatient care when conducted by a physician, audiologist, or other qualified provider. Humana also covers:

- Basic and advanced hearing tests
- Hearing aid counseling
- Hearing aid evaluation and fitting
- Hearing aids every three years
- Hearing aid batteries and accessories
- Hearing aid repair and replacement parts

### HIV screening

Humana pays for one HIV screening every 12 months for members who:

- Request an HIV screening test
- Are at increased risk for HIV infection

For pregnant women, Humana pays for up to three HIV screening tests during a pregnancy

### Home health agency care

Before receiving home health services, a doctor must confirm member need, and those services must be provided by a home health agency. Humana will cover various services, including:

- Part-time or intermittent skilled nursing and home health aide services. (When covered under the home healthcare benefit, skilled nursing and home health aide services combined must total fewer than eight hours per day and 35 hours per week)
- Physical therapy, occupational therapy and speech therapy
- Medical and social services
- Medical equipment and supplies

### Home infusion therapy

Humana pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to members at home. The following are needed to perform home infusion:

- The drug or biological substance, such as an antiviral or immune globulin;
- Equipment, such as a pump; and
- Supplies, such as tubing or a catheter.

Humana covers home infusion services that include but are not limited to:

- Professional services, including nursing services, provided in accordance with the member's care plan;
- Member training and education not already included in the DME benefit;
- Remote monitoring; and
- Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.

### Hospice care

Members can receive care from any Medicare-certified hospice program and have the right to elect hospice if a terminal prognosis is assessed by a member's provider and the hospice medical director.

**NOTE:** Medicare-certified hospice and Medicare Part A and B services related to terminal illness are covered by Medicare. Humana Gold Plus Integrated (Medicare-Medicaid Plan) does not pay for those member services.
A terminal illness is defined as the determination that a member has six months or less to live. The hospice doctor can be a network provider or an out-of-network provider.

Humana covers the following while members receive hospice services:

- Drugs to treat symptoms and pain
- Short-term respite care
- Home care, including home health aide services
- Occupational, physical and speech-language therapy services to control symptoms
- Counseling services

Hospice services and services covered by Medicare Part A or B are billed to Medicare

Humana Gold Plus Integrated (Medicare-Medicaid Plan) pays for plan-covered services not covered under Medicare Part A or B. Humana covers the free services even when they are not related to the member's terminal prognosis. For drugs that may be covered by Humana Gold Plus Integrated (Medicare-Medicaid Plan) Medicare Part D benefit:

- Drugs are never covered by both hospice and Humana

**NOTE:** Members needing non-hospice care should call a Customer Care coordinator at **800-787-3311 (TTY: 711)** to arrange for assistance. Coordinators are available Monday through Friday, 7 a.m. – 7 p.m., Central time. Our automated phone system may answer after-hours calls, during weekends and holidays. A member must provide their name and telephone number, and a coordinator should respond by the end of the next business day. Visit **Humana.com** for 24-hour access to information such as claims history, eligibility and Humana's drug list. Members can obtain health news and information and use the **Physician Finder**.

**NOTE:** Providers must notify Humana of a member's hospice status immediately on discovery.

### Immunizations

Humana covers the following services:

- Pneumonia vaccine
- Flu shots, once a year (during fall or winter months)
- Hepatitis B vaccine (if members are at immediate/high risk of contracting the disease)
- Other vaccines (if member is at risk and meets Medicare Part B coverage rules)

Humana covers other vaccines that meet the Medicare Part D coverage rules.

### Inpatient hospital care (referral also may be required)

NOTE: Members must receive plan approval to keep receiving inpatient care at an out-of-network hospital after an emergency condition is stabilized. Services Humana covers include:

- Semi-private room (or a private room if medically necessary)
- Regular nursing services
- Drugs and medications
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Physician services
- Inpatient substance abuse services
- Meals (including special diets)
- Special care units (such as intensive or coronary care units)
- Lab tests
- Appliances, such as wheelchairs
- Operating and recovery room services
- Physical, occupational and speech therapy
- Blood storage, blood components and administration

Humana will, in some cases, cover the following transplant services:

- Liver
- Kidney
- Lung
- Kidney/pancreatic
- Heart/lung
- Heart
- Bone marrow
- Stem cell
- Intestinal/multi-visceral
- Ventricular assist device (VAD)
- Chimeric antigen receptor T-cell therapy (CAR-T)

If the member needs a transplant, Humana arranges for a case review by a Medicare-approved transplant center that decides whether the member is a candidate for a transplant. Transplant providers may be local or outside the service area. If an in-network transplant service is outside the community pattern of care, members may choose to go locally as long as the local transplant providers are willing to accept the original Medicare rate. If Humana Gold Plus Integrated (Medicare-Medicaid Plan) provides transplant services at a location outside the pattern of care for transplants in the member's community and they choose to obtain transplants at this distant location, Humana arranges or pays for appropriate lodging and transportation costs for the member and one companion. If the member needs a solid organ or bone marrow/stem-cell transplant, please call our Transplant Department at **866-421-5663** for important information regarding transplant care.

### Inpatient mental healthcare

Humana covers medically necessary psychiatric inpatient care at approved institutions.

### Inpatient services covered during a non-covered stay

Humana does not cover unnecessary inpatient member stays. However, in some cases Humana will cover member services received during a hospital or nursing facility stay.

Humana will cover the following (and may cover other) services:

- Doctor services
- Diagnostic tests, such as lab tests
- X-ray, radium and isotope therapy, including technician materials and services
- Surgical dressings
- Splints, casts and other devices used for fractures and dislocations
- Prosthetics and orthotic devices (other than dental), including device replacement or repair. These devices:
  - Replace all or part of an internal body organ (including contiguous tissue)
  - Replace all or part of the function of an inoperative or malfunctioning internal body organ
- Leg, arm, back and neck braces, trusses as well as artificial legs, arms and eyes. This includes adjustments, repairs and replacements needed because of breakage, wear, loss, or a change in the patient's condition
- Physical, speech and occupational therapy

### Kidney disease services and supplies

Humana covers the following services:

- Kidney disease education services to teach organ care and help members make good care decisions. Members must have stage IV chronic kidney disease and be doctor-referred. Humana covers up to six sessions of kidney disease education services
- Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area
- Inpatient dialysis treatments, if admitted for inpatient hospital special care
- Self-dialysis training for members and caregivers that help with home dialysis treatments
- Home dialysis equipment and supplies
- Certain home support services, such as necessary trained dialysis worker visits to check home dialysis equipment, help during emergencies and to check water supply

The member's Medicare Part B drug benefit pays for some dialysis drugs. For information, please see "Medicare Part B prescription drugs" in this chart.

### Lung cancer screening

Humana pays for lung cancer screening every 12 months if a member:

- Is 55-77 years old
- Has counseling and shared decision-making with a doctor or other qualified provider, and
- Has smoked at least one pack a day for 30 years with no signs or symptoms of lung cancer, or
  - Current smoker
  - Has quit within the past 15 years

After the first screening, Humana pays for a screening each year with a written order from a qualified provider.

Medical equipment and related supplies

The following general types of services and items are covered:

- Non-durable medical supplies, including surgical dressings, bandages, disposable syringes, incontinence supplies, ostomy supplies and enteral nutrition therapy
- Durable medical equipment, including wheelchairs, crutches, walkers, hospital beds, IV infusion pumps and supplies and humidifiers
- Prosthetic and orthotic devices, compression stockings, shoe orthotics, arch supports and foot inserts
- Respiratory equipment and supplies, including oxygen equipment, CPAP and BIPAP equipment
- Repair of durable medical equipment, prosthetic and orthotic devices
- Rental of medical equipment, when a member's needs are temporary

To be eligible for reimbursement, some services may be subject to prior approval and/or medical criteria. Humana pays for all medically necessary durable medical equipment usually covered by Medicare and Medicaid. If our supplier in the member's area does not carry a particular brand or maker, they may request that items be special ordered.

### Medical nutrition therapy

This benefit is for members with diabetes or kidney disease without dialysis. It can also be used after a kidney transplant when referred by their doctor.

Humana covers three hours of one-on-one counseling services during the member's first year that they get medical nutrition therapy services under Medicare. (This includes Humana, any other Medicare Advantage plan or Medicare.) We cover two hours of one-on-one counseling services each year after that.

If the member's condition, treatment or diagnosis changes, they may be eligible for additional treatment hours with a doctor's referral. A doctor must prescribe these services and renew the referral each year if the member's treatment is needed in the next calendar year.

### Medicare diabetes prevention program

Humana pays for Medicare diabetes prevention program (MDPP) services. MDPP is designed to help members increase healthy behavior. It provides practical training in:

- Making long-term dietary changes
- Increasing physical activity
- Incorporating new methods to maintain weight loss and a healthy lifestyle

### Medicare Part B prescription drugs

Defined as those medications covered under Part B of Medicare, Humana Gold Plus Integrated (Medicare-Medicaid Plan) covers the following drugs:

- Drugs that are injected or infused while members receive doctor, hospital outpatient or ambulatory surgery center services
- Drugs that use plan-authorized durable medical equipment (such as nebulizers)
- Self-administered clotting factor injections for members with hemophilia
- Immunosuppressive drugs for Medicare Part A-enrolled members at the time of organ transplant
- Injected osteoporosis drugs for homebound members with a bone fracture that a doctor certifies is related to post-menopausal osteoporosis and cannot be self-injected
- Antigens
- Certain oral anti-cancer and anti-nausea drugs
- Certain home dialysis drugs, including heparin, the antidote for heparin (when medically necessary), topical anesthetics and erythropoiesis-stimulating agents (such as Epogen® or Procrit®)
- IV-immune globulin for home treatment of primary immune deficiency diseases
- Chemotherapy drugs and administration

### Non-emergency transportation

Humana covers member transportation to or from medical appointments if the service is covered. Types of non-emergency transportation include:

- Non-emergency ambulance
- Shared service car
- Taxi

Unlimited round trips per year by taxi, bus or subway, passenger van or medical transport are covered when traveling to nursing homes, pharmacies (immediately following doctor visits) and other medical providers and locations.
Prior authorization and/or referral may be required.

### Non-Medicaid over-the-counter drugs

Members are eligible for an allowance of up to $65 per quarter to purchase products that support common occurring conditions such as:

- Pain relievers
- Cough and cold relief medicine
- First aid equipment that does not require prescription

Unused allowance amounts do not roll over to the next quarter.
Members may purchase over-the-counter health and wellness products available through CenterWell®, Humana's mail-order pharmacy.

### Nurse advice call line (HumanaFirst®)

Members who have symptom questions and concerns can call HumanaFirst – our member advice line — 24 hours a day, 7 days a week at **855-235-8530 (TTY: 711)**. The call center is staffed by nurses who can address immediate member health concerns and answer questions about medical conditions.

### Nursing-facility care and skilled-nursing facility care

Humana covers skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). Humana will pay for the following services and maybe other services not listed here:

- A semi-private or private room (if medically necessary), maintenance and cleaning
- Meals, including special meals, food substitutes and nutritional supplements
- Nursing services and resident supervision/oversight
- Physician services
- Physical, occupational and speech therapy
- Physician-ordered medications available through a pharmacy without a prescription as part of the member's plan of care (including self-administered over-the-counter medications)
- Non-custom durable medical equipment (such as wheelchairs and walkers)
- Medical and surgical supply items, such as bandages, oxygen administration supplies, oral care supplies and equipment, and one tank of oxygen per resident per month
- Additional services provided by a nursing facility in compliance with state and federal requirements

Members may receive out-of-network facility care if the facility accepts Humana's out-of-pocket payment amounts. Applicable situations include:

- A nursing home or continuing care retirement community where the member lived before their hospital stay, as long as it provides nursing facility care
- A nursing facility where the member's spouse lives after the member's hospital release. Prior authorization and/or referral may be required.

NOTE: When member income exceeds an allowable amount, the member must contribute toward the cost of services. This is known as the patient pay amount and is required if a member lives in a nursing facility.
Patient pay responsibility does not apply to Medicare-covered days in a nursing facility.

### Obesity screening and weight management therapy

Members with a body mass index (BMI) of 30 or greater may receive plan-covered counseling to help with weight loss. Counseling must be received and managed in a primary care setting as part of the member's full prevention plan.

### Opioid treatment program services

Humana covers the following services to treat opioid use disorder (OUD):

- Intake activities
- Periodic assessments
- Medications approved by the Food and Drug Administration (FDA) and, if applicable, management and administration of medications
- Substance use counseling
- Individual and group therapy
- Testing for drugs or chemicals in the member's body (toxicology testing)

### Outpatient diagnostic tests and therapeutic services

Humana covers the following (and possibly other) services:

- X-rays
- Radiation (radium and isotope) therapy, including technician materials and supplies
- Lab tests
- Blood, blood components and their administration
- Other outpatient diagnostic tests:
  - Surgical supplies, such as dressings
  - Splints, casts and other devices used to treat fractures and dislocations
  - Home or facility-based sleep studies
  - Diagnostic mammography

Prior authorization and/or referral may be required.

### Outpatient hospital services

Humana pays for medically necessary services members receive through the outpatient department of a hospital for diagnosis or treatment of an illness or injury.

Humana covers the following services, and maybe other services not listed here:

- Emergency department or outpatient clinic services (i.e., observation services or outpatient surgery)
  - Sometimes a member can be in the hospital overnight and still be classified as an “outpatient”
- Labs and diagnostic tests billed by the hospital
- Mental healthcare, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it
- X-rays and other radiology services billed by the hospital
- Medical supplies, including splints and casts
- Preventive services and preventive screenings
- Some drugs that cannot be self-administered, including:
  - Nuclear medicine services
  - Radiation therapy

Prior authorization and/or referral may be required.

### Outpatient mental healthcare

Humana covers mental health services provided by:

- A state-licensed psychiatrist or doctor
- A clinical psychologist
- A clinical social worker
- A clinical nurse specialist
- A nurse practitioner (NP)
- A physician assistant (PA)
- A licensed clinical professional counselor (LPC)
- Community mental health centers (CMHCs)
- Behavioral health clinics (BHCs)
- Hospitals
- Encounter rate clinics—e.g., federally qualified health centers (FQHCs)
- Any other Medicare-qualified mental healthcare professional as allowed under applicable state laws

Humana covers the following types of outpatient mental health services:

- Clinic services provided under the direction of a physician
- Rehabilitation services recommended by a physician or Licensed Practitioner of the Healing Arts, such as Integrated Assessment and Treatment Planning, crisis intervention, therapy and case management
- Day treatment services
- Outpatient hospital services, such as Type A and B clinic service options
- Substance use treatment

The utilization controls on the specific provider services listed above are determined by Humana, in accordance with federal and state laws and all applicable policies and/or agreements.

### Outpatient mental health crisis services (expanded)

In addition to crisis intervention services, Humana covers the following medically necessary crisis services:

- Mobile crisis response (MCR): MCR is a mobile, time-limited service for crisis symptom reduction, stabilization and restoration to the previous level of functioning.
  - MCR services require a face-to-face screening using a state approved crisis-screening instrument and may include short-term intervention, crisis safety planning, brief counseling, consultation with other qualified providers, and referral to other mental health community services.
  - To access MCR services, health plan members or individuals concerned about health plan members should call the state's crisis intake line, CARES, at **800-345-9049 (TTY: 866-794-0374)**. CARES dispatches a local provider to the location of the Humana member in crisis.
- Crisis stabilization: Crisis stabilization services are time-limited, intensive supports available for up to 30 days following an MCR event to prevent additional behavioral health crises. Crisis stabilization services provide strengths-based support on a one-on-one basis in the home or community.

Humana covers MCR and crisis stabilization services provided by:

- Community mental health centers with a crisis certification from the state, or
- Behavioral health clinics with a crisis certification from the state.

### Outpatient rehabilitation services

Humana covers physical therapy, occupational therapy and speech therapy.

Rehabilitation services are available from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs) and other facilities. Prior authorization and/or referral may be required.

### Outpatient surgery

Humana covers outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. Prior authorization and/or referral may be required.

### Partial hospitalization services

Partial hospitalization is defined as a structured program of active psychiatric treatment offered in an outpatient hospital setting or by a community mental health center. To prevent inpatient hospital stays, it offers a more intense level of care in comparison to the member's doctor or therapist office.

Prior authorization and/or referral may be required.

### Physician/provider services including doctor's office visits

Humana covers the following services:

- Medically necessary healthcare or surgery services given in places including:
  - Physician's office
  - Certified ambulatory surgical center
  - Hospital outpatient department
- Specialist consultation, diagnosis, and treatment
- Hearing and balance exams ordered by a primary care provider to assess treatment needs
- Telehealth services for monthly end-stage renal disease (ESRD)-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility or the member's home
- Telehealth services to diagnose, evaluate or treat symptoms of a stroke
- Telehealth services for members with a substance use disorder or co-occurring mental health disorder
- Telehealth services for diagnosis, evaluation and treatment of mental health disorders if:
  - The member has an in-person visit within six months prior to the first telehealth visit
  - The member has an in-person visit every 12 months while receiving these telehealth services
  - Exceptions can be made to the above for certain circumstances
- Telehealth services for mental health visits provided by rural health clinics and federally qualified health centers
- Virtual 5- to 10-minute provider check-ins (e.g., by phone or video chat) are viable if:
  - The member is not a new patient and
  - The check-in is unrelated to an office visit made within the past 7 days and
  - The check-in doesn't lead to an office visit within 24 hours or earliest-available appointment
- Consultation a doctor has with other doctors by phone, over the internet, or electronic health record if the member is not a new patient
- Second opinion before a medical procedure from a network provider
- Non-routine dental care covered services are limited to:
  - Surgery of the jaw or related structures
  - Setting fractures of the jaw or facial bones
  - Pulling teeth before radiation treatments of neoplastic cancer, or
  - Services that would be covered when provided by a physician

Prior authorization and/or referral may be required.

### Podiatry services

Humana covers the following services:

- Diagnosis and medical or surgical treatment of foot injuries and diseases (such as hammer toe or heel spurs)
- Routine foot care for members with conditions affecting the legs, such as diabetes

Members are covered for additional podiatry benefits and may self-refer to a network specialist for up to six visits each year for the following services:

- Members in need of medical or surgical treatment of injuries and diseases of the foot
- Members with conditions affecting the legs, such as diabetes

Prior authorization and/or referral may be required.

### Post-discharge meal program

After an inpatient hospital or residential facility stay, members may receive up to 14 home-delivered meals, limited to four discharges per year. Please call Well Dine at **866-96MEALS (866-966-3257) (TTY: 711)** for further details or to take advantage of this discharge benefit.

### Prostate cancer screening exams

Humana covers a digital rectal exam and a prostate-specific antigen (PSA) test once every 12 months for:

- Men 50 and older
- African American men 40 and older
- Men 40 and older with a family history of prostate cancer

### Prosthetic devices and related supplies

Prosthetic devices replace all or part of a body part or function. Humana covers the following prosthetic devices, and maybe other devices not listed here:

- Colostomy bags and supplies related to colostomy care
- Pacemakers
- Braces
- Prosthetic shoes
- Breast prostheses (including a surgical brassiere after a mastectomy)
- Artificial arms and legs

Humana also covers some supplies related to prosthetic devices and for prosthetic device replacement or repair. Humana also offers some coverage after cataract removal or cataract surgery.
Prior authorization and/or referral may be required.

### Pulmonary rehabilitation services

Humana covers pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD).

The member must have a referral for pulmonary rehabilitation from the doctor or provider treating the COPD. Referral may be required.

### Sexually transmitted infections screening and counseling

Humana covers the following screenings for pregnant women and plan members at increased sexually transmitted infection (STI) risk once every 12 months (or at certain times during pregnancy):

- Chlamydia
- Gonorrhea
- Syphilis
- Hepatitis B

Humana also covers up to two 20- to 30-minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Humana covers these counseling sessions as a preventive service only if provided by a PCP. The sessions must take place in a primary care setting, such as a doctor's office.

### Smartphone services

Free cell phone through the federal Lifeline program, per household.

This benefit covers the following per lifetime: one phone, one charger, one set of instructions, 350 minutes per month, 4.5 GB of data per month, unlimited text messages per month, training for a member and their caregiver at the first case manager orientation visit. This benefit also includes unlimited calls to Humana member services for health plan assistance and 911 for emergencies even if the member runs out of minutes. Members must make at least one phone call or send one text message every month to keep their benefit.

The member may also qualify for enhanced benefits through the Affordable Connectivity Program (ACP) that provides unlimited minutes, five GB hotspot and 25 GB of data. Members can opt into this benefit by contacting SafeLink at **877-631-2550** or online at **www.safelink.com**.

Benefits are subject to change by the Federal Communications Commission under the Lifeline program.

### Substance use services

Humana covers substance use services provided by:

- A state-licensed substance abuse facility or
- Hospitals

Humana covers the following types of medically necessary substance use services:

- Group or individual outpatient services such as assessment, therapy, medication monitoring and psychiatric evaluation
- Medication-assisted treatment (MAT) for opioid dependency (including ordering and administering methadone), managing a care plan, and coordinating other substance use disorder services
- Intensive outpatient services (group or individual)
- Detoxification services, and
- Some residential services, such as short-term rehabilitation services

### Supervised exercise therapy

Humana pays for supervised exercise therapy (SET) for members with symptomatic peripheral artery disease (PAD) who were referred by the treating peripheral artery disease (PAD) physician. Humana pays for:

- Up to 36 sessions during a 12-week period if all SET requirements are met
- An additional 36 sessions over time if deemed medically necessary by a healthcare provider

The SET program must be:

- 30- to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication)
- Delivered in a hospital outpatient setting or in a physician's office
- Delivered by qualified personnel who ensure that benefit exceeds harm and are trained in exercise therapy for PAD
- Performed under the direct supervision of a physician, physician assistant or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques

### Transplant services

The Humana transplant services team helps members and their physicians navigate the complex world of transplant care and make informed decisions by:

- Explaining the benefit structure and helping members maximize their benefits
- Providing education on the transplant process
- Helping members choose a transplant program
- Dedicating transplant care managers for authorization and care management services
- Dedicating specially trained staff to handle claims quickly and efficiently

To reach Humana's team of transplant care managers, call **866-421-5663**, email **transplant@humana.com** or fax **502-508-9300**. Care managers are available to assist you Monday through Friday, 7 a.m. to 4 p.m., central time. Messages left after hours will receive a response the next business day.

### Urgently needed care

Urgently needed care is care given to treat:

- A non-emergency, or
- A sudden medical illness, or
- An injury, or
- A condition that needs care right away.

If a member requires urgently needed care, they should first try to get it from a network provider. However, members can use out-of-network providers when they cannot get to a network provider. Members are covered for urgently needed care in the U.S. and its territories.

### Vision care

Humana covers the following:

- Annual routine eye exams
  - Eyeglasses (lenses and frames)
  - Frames limited to one pair in a 24-month period
- Lenses limited to one pair in a 24-month period, but members may get more when medically necessary, with prior approval
- Custom-made artificial eye
- Low vision devices
- Contacts and special lenses when medically necessary, with prior approval

To be eligible for reimbursement, some services may be subject to prior approval and/or medical criteria.
Humana covers outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, Humana covers an annual eye exam for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.

Humana covers one glaucoma screening each year for people at high risk of glaucoma, including:

- People with a family history of glaucoma,
- People with diabetes,
- African Americans who are 50 and older, and
- Hispanic Americans who are 65 or older

Humana covers one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If the member has two cataract surgeries, the member must get one pair of glasses after each surgery. The member cannot get two pairs of glasses after the second surgery, even if they did not get a pair of glasses after the first surgery.

### 'Welcome to Medicare' preventive visit

Humana covers the one-time "Welcome to Medicare" preventive visit. The visit includes:

- Member health review
- Necessary member preventive service education and counseling, including screenings and shots
- Necessary member referrals for other care

**NOTE:** Humana covers the "Welcome to Medicare" preventive visit only during the first 12 months of a member's Medicare Part B coverage. Please encourage members to schedule the preventive visit when scheduling a doctor's appointment.

## Excluded benefits – Humana Gold Plus Integrated, Medicare–Medicaid Plan

The following benefits are excluded from plan coverage. Excluded benefits are defined as services covered by neither this plan, Medicaid or Medicare. Some services and items are not covered by Humana at all, while others are excluded only in some cases.

- Services considered not "reasonable and necessary," according to the standards of Medicare and Medicaid, unless these services are listed by Humana as covered services.
- Experimental medical and surgical treatments, items and drugs, unless covered by Medicare, considered part of a Medicare-approved clinical research study or covered by Humana
- Experimental treatment and items not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically necessary and Medicare pays for it
- A private hospital room, except when medically necessary
- Private duty nurses
- Personal items in the member's room at a hospital or a nursing facility, such as a telephone or a television
- Full-time nursing care in a member's home
- Fees charged by the member's immediate relatives or household members
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary

- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. (However, Humana covers breast reconstruction after a mastectomy and for treating the other breast to match it.)
- Preventive dental care. Refer to the dental services topic for more information on dental coverage
- Naturopath services (the use of natural or alternative treatments)
- Veteran services provided in Veterans Affairs (VA) facilities (NOTE: When a veteran receives emergency VA hospital services and the VA cost-sharing cost exceeds the cost sharing under Humana, Humana reimburses the veteran for the difference. Members are still responsible for their cost-sharing amounts.)
- Chiropractic care (other than manual spine manipulation) that is consistent with Medicare coverage guidelines
- Radial keratotomy, LASIK surgery and vision therapy
- Reversal of sterilization procedures
- Partial dentures

Members who believe that an excluded service should be covered may file an appeal. For information about filing an appeal, see Grievance and appeals system.

# Utilization management

Our Utilization Management (UM) Program is designed to ensure members receive access to the right care in the right place at the right time. Our goal is to optimize the member's benefits by providing quality healthcare services that:

- Meet professionally recognized standards of care;
- Are a covered benefit, medically necessary and appropriate for the individual member's condition; and
- Provided at the most appropriate level of care.

## Preauthorization

Preauthorization is defined as a process through which the physician or other healthcare provider is required to obtain advance approval from Humana as to whether an item, drug or service will be covered.

Notification refers to the process of the physician or other healthcare provider notifying Humana of the intent to provide an item, drug or service. Humana may request notification, as this helps coordinate care for your Humana-covered patients. This process is distinguished from preauthorization, as it does not result in an approval or denial.

Our preauthorization list can be found at Humana.com/PAL. You also can call Provider Services at 800-787-3311 to request a hard copy of the list. Please note that the preauthorization list is subject to change.

Requests for preauthorization should be made as soon as possible but at least 14 days in advance of the service date. Note: Emergent/urgent care does not require preauthorization. However, providers should notify Humana within 48 hours for initiation of these services.

If preauthorization is required and not obtained, it may result in reduction or denial of payment. Services provided without preauthorization also may be subject to retrospective review. When retrospective review is performed, providers should include clinical information to perform a medical necessity review, as well as a summary of why preauthorization was not obtained.

## How to request a preauthorization

To initiate a preauthorization or notification request, a provider can:

- Visit **Availity.com** (registration required). For many services that require preauthorization, you can answer a series of questions when requesting the preauthorization. If approved, you will receive notification immediately. If pended for further review, you can attach relevant clinical information to the request to expedite the process.
- Submit a B2B or batch Health Care Services Review and Response transaction (278) via EDI.
- Use our interactive voice response system (IVR) by calling **800-523-002**3.
- Call the number for precertification on the back of the patient's Humana ID card.
- Fax the request to **855-227-0677**.

If a request needs to be expedited due the seriousness of a patient's condition, call **800-523-0023**.

## Required information for a preauthorization request or notification

Information required for a preauthorization request or notification may include, but is not limited, to:

- Member's Humana ID number, name and date of birth
- Date of actual service or hospital admission
- Procedure codes, up to 10 maximum per authorization request
- Date of proposed procedure, if applicable
- Diagnosis codes (primary and secondary), up to six maximum per authorization request
- Service location
- Inpatient location (acute hospital, skilled nursing, hospice)
- Outpatient location (telehealth, office, home, off-campus outpatient hospital, on-campus outpatient hospital, ambulatory surgery center)
- Referral (office, off-campus outpatient hospital, on-campus outpatient hospital, ambulatory surgery center, other)
- Tax Identification Number (TIN) and National Provider Identifier (NPI) of treatment facility where service is rendered
- TIN and NPI of the provider performing the service
- Caller/requestor's name and telephone number
- Attending physician's telephone number

- Relevant clinical information
- Discharge plans

Submitting all relevant clinical information at the time of the request facilitates a faster determination. If additional clinical information is required, a Humana representative will request the specific information needed to complete the authorization process.

## Referrals

If a patient requires specialized treatment beyond the scope of a primary care physician (PCP), they can be referred to a specialist for consultation and/or treatment. Humana contracts with specialists in the plan's service area. See the providers' section of Humana.com for Humana's claims payment policy on ordering provider and referring provider requirements. Referrals are not required to see some specialists, such as women health specialists.

The PCP initiates the referral by submitting a referral request through **Availity.com**. Methods for submitting referral requests are outlined in the preauthorization section above and on Humana's website. The PCP receives a referral number from Humana if the referral request is: 1) completed and Humana determines the services are covered under the provider agreement; 2) provided by an approved provider/facility; and 3) medically necessary. An approved referral number does not override member eligibility, provider agreement exclusions, etc. Prior to the specialist rendering services, preauthorization also must be obtained by the specialist for any additional medications or services on the preauthorization and notification list.

The status of a referral can be verified by accessing **Availity.com** or by calling **800-523-0023**. After the patient has been treated, the specialist's findings, diagnosis and recommendation for treatment should be sent to the patient's PCP. The specialist also must submit claim/encounter data to Humana.

Preauthorization for medications and services on the preauthorization and notification list is required. The list is at **Humana.com/PAL** under the Medicare tab, or call **800-4HUMANA** to request a copy.

NOTE: Original Medicare does not cover some services or supplies when ordered/referred unless certain requirements (e.g., qualifications of the ordering/referring provider, billing requirements) are satisfied. For MMAI members, Humana follows Original Medicare billing and enrollment requirements for services and supplies covered under Original Medicare, which includes Part A and Part B only.

## Inpatient coordination of care/concurrent review

Concurrent review is the process that determines coverage during the inpatient stay, including, but not limited to, acute inpatient facility, skilled nursing facility (SNF), long- term acute care hospital (LTAC) and inpatient rehabilitation facility. Each admission is reviewed for medical necessity and compliance with contractual requirements. Humana contacts the provider if additional clinical review is required.

In addition to the information provided for the initial admission, providers should indicate any complicating factors that prevent discharge. Providers also must contact Humana with the discharge date and discharge disposition on patient discharge.

If coverage guidelines for an inpatient stay are not met and/or the member's certificate of coverage does not provide the benefit, a licensed medical professional from Humana will consult with the PCP and/or facility utilization management and discharge planning staff. If necessary, the licensed medical professional will refer the case to a Humana medical director for review and possible consultation with the attending physician. If the medical director determines that coverage guidelines for continued hospitalization are no longer valid, the facility should follow the instructions under the "Special requirements for hospitals" section.

## Discharge planning

The Humana UM team collaborates with the Humana-covered patient and their family or guardian, the hospital's UM and discharge planning departments and the patient's attending physician/PCP to facilitate the discharge plan, including identifying the most appropriate post-discharge level of care.

## Clinical review guidelines

Humana uses nationally accepted clinical guidelines to determine the medical necessity of services. The review guidelines are used as a screening guide to review services during the utilization management process. For MMAI plans, Humana applies Medicare national coverage determinations (NCDs) and local coverage determinations (LCDs) as well as Illinois Medicaid coverage guidelines. Humana also develops internal clinical policies, Humana medical coverage policies (HMCPs), based on peer-reviewed literature.

A licensed, board-certified medical director reviews all available clinical documentation to confirm guidelines are met. The medical director renders a decision in accordance with clinical review guidelines and currently accepted medical standards of care, taking into account the individual circumstances of each case. If you receive an adverse determination, you will receive a denial letter that includes the criteria used to make the decision. You can also obtain the guidelines used to make a specific adverse determination by contacting Humana at **800-322-2758**, option 2, ext. 1500130.

## Peer-to-peer review

Prior to or at the time an adverse determination is communicated, the provider ordering services may be given an opportunity to discuss the services being requested for the member and the clinical basis for treatment with a medical director or other appropriate reviewer.

For MMAI plans, the discussion must be completed prior to the adverse determination being rendered. Once an adverse determination is made, participating providers are given the opportunity to submit a provider dispute. A participating provider may submit a dispute prior to submitting a claim under the following circumstance:

- Humana's adverse determination was based on lack of medical necessity for an authorization request that was retrospective (retro) or concurrent to the service.

Physicians/providers have five calendar days from notification of the denied authorization to request the pre-claim dispute. As part of this pre-claim dispute, providers can request a peer-to-peer conversation if one did not occur prior to the adverse determination. Participating providers also can submit claim disputes via the outlined claims dispute process section of this manual.

## Second medical opinion

A member has the right to a second medical opinion in any instance in which the member questions the reasonableness, necessity or lack of necessity for the following:

- Surgical procedures
- Treatment for a serious injury or illness
- Other situations in which members feel that they are not responding to the current treatment plan in a satisfactory manner

Follow-up services must be obtained through or arranged by the member's PCP.

## Special requirements for hospitals

### Hospital discharge rights for MMAI members

CMS requires that hospitals deliver the Important Message from Medicare (IM), CMS-10065, to all Medicare beneficiaries, including MMAI plan members who are hospital inpatients. Hospitals are required to provide the IM to the MMAI member on admission and at least two days prior to the anticipated last covered date. The notice must be given on the standardized CMS IM form. The form and instructions regarding the IM are on the **CMS website**.

The IM informs hospitalized MMAI beneficiaries about their hospital discharge appeal rights. MMAI members who are hospital inpatients have the statutory right to request an immediate review by a quality improvement organization (QIO) when Humana, along with the hospital and physician, determines that inpatient care is no longer necessary.

### Guidelines for IM notification by telephone

If the hospital staff is unable to personally deliver the IM to the patient or their representative, then the hospital staff should telephone the representative to advise them of a member's rights as a hospital patient, including the right to appeal a discharge decision. At a minimum, the telephone notification should include:

- The name and telephone number of a contact at the hospital
- The beneficiary's planned discharge date and the date when the beneficiary's liability begins

- The beneficiary's rights as a hospital patient, including the right to appeal a discharge decision
- How to get a copy of a detailed notice describing why the hospital staff and physician believe the beneficiary is ready to be discharged
- A description of the steps for filing an appeal
- When (by what time/date) the appeal must be filed to take advantage of the liability protections
- To whom to appeal, including any applicable name, address, telephone number, fax number or other method of communication the entity requires to receive the appeal in a timely fashion

**NOTE:** The date that the hospital staff conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice.

The hospital is required to:

- Confirm the telephone contact by written notice mailed to the member's authorized representative on that same date.
- Place a dated copy of the notice in the member's medical file and document the telephone contact with either the member or their representative on either the notice itself or in a separate entry in the member's file.
- Ensure that the documentation indicates that the staff person told the member or representative the planned discharge date, the date that the beneficiary's financial liability begins, the beneficiary's appeal rights and how and when to initiate an appeal. Ensure the documentation includes the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of telephone contact and the telephone number called.

When direct phone contact with a member's representative cannot be made, the hospital must:

- Send the notice to the representative by certified mail (return receipt requested) or via another delivery method that requires signed verification of delivery. The date of signed verification of delivery (or refusal to sign the receipt) is the date received.
- Place a copy of the notice in the member's medical file and document the attempted telephone contact to the representative.

Ensure that the documentation includes:

- The name of the staff person initiating the contact
- The name of the member or member's representative
- The date and time of the attempted call
- The telephone number called

### Right to appeal a hospital discharge

When members choose to appeal a discharge decision, the hospital or their Medicare health plan must provide them with the Detailed Notice of Discharge (DND). These requirements were published in a final rule, CMS-4105-F: Notification of Hospital Discharge Appeal Rights, which became effective July 2, 2007.

When the QIO notifies the hospital and Humana of an appeal, Humana provides the hospital with a DND. The hospital is responsible for delivering the DND as soon as possible to the member or their authorized representative on behalf of Humana, but no later than 12 p.m. local time of the day after the QIO notifies Humana or the hospital of the appeal. The facility must fax a copy of the DND to the QIO and to Humana.

If the member misses the time frame to request an immediate review from the QIO and remains in the hospital, they can request an expedited reconsideration (appeal) through Humana's appeals department. For more information about notification of termination requirements, providers can visit the **CMS website**.

### Medicare Outpatient Observation Notice (MOON) Requirement

The Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE ACT) Public Law 114-42 was passed Aug. 6, 2015, and amended Section 1866(a)(1) of the Social Security Act. The amendment requires hospitals and critical access hospitals (CAHs) to provide the Medicare Outpatient Observation Notice (MOON) to Original Medicare beneficiaries and MMAI plan members or their authorized representatives. This includes beneficiaries who do not have Part B coverage, beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON and beneficiaries for whom Medicare is the primary or secondary payer. The MOON is intended to inform beneficiaries who receive observation services for more than 24 hours that they are outpatients, not inpatients, and the reasons for their status.

### Additional important information

- Effective March 8, 2017, hospitals and CAHs are responsible to provide the written MOON and a verbal explanation of the notice to all Original Medicare and MMAI beneficiaries who receive outpatient observation services for more than 24 hours.
- The MOON must be provided to the beneficiary (or the beneficiary's authorized representative) no later than 36 hours after observation services begin and may be delivered before a beneficiary receives 24 hours of observation services as an outpatient.
- If the beneficiary is transferred, discharged or admitted, the MOON still must be delivered no later than 36 hours following initiation of observation services.
- The start time of observation services is measured as the clock time observation services were initiated in accordance with a physician's order.
- Hospitals and CAHs must use the Office of Management and Budget (OMB)-approved MOON (CMS-10611) and instructions available on the **CMS website**.

Additional information about the MOON can be found on the **CMS Medicare Learning Network site**.

## Special requirements for skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities

### Medicare Advantage (MA) plan members

Notice of Medicare Non-Coverage (NOMNC): The Centers for Medicare & Medicaid Services (CMS) requires that healthcare providers give the Notice of Medicare Non-Coverage (NOMNC) to Medicare Advantage (MA/MMAI) Humana members at least two days prior to termination of skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services. Additionally, if the member's SNF services are expected to be fewer than two calendar days, the NOMNC should be delivered at the time of admission. For HHA or CORF services, the notice needs to be given no later than the next-to-the-last time services are furnished. The NOMNC informs members how to request an expedited determination from their QIO if they disagree with the termination.

The form and instructions regarding the NOMNC are available on the **CMS website**.

Providers also can contact their QIO for forms or additional information. Forms also can be obtained from Humana's local health services utilization management department. No modification of the text on the CMS NOMNC is allowed. For the NOMNC to be valid:

- The member must be able to comprehend and fully understand the notice contents.
- The member or their authorized representative must sign and date the notice as proof of receipt.
- The notice must be the standardized CMS NOMNC form.

If a member refuses to sign the NOMNC, the member's refusal to sign, the date, time, name of person who witnessed the refusal and their signature must be documented on the NOMNC. Valid delivery does not preclude the use of assistive devices, witnesses or interpreters for notice of delivery. Any assistance used with delivery of the notice also must be documented. If a member is not able to comprehend and fully understand the NOMNC, a representative may assume responsibility for decision-making on the member's behalf; in such cases, the representative, in addition to the member, must receive all required notifications. The following specific information is required to be given when contacting a member's representative of the NOMNC by phone:

- The member's last day of covered services and the date when the beneficiary's liability is expected to begin
- The member's right to appeal a coverage termination decision
- A description of how to request an appeal by a QIO
- The deadline to request a review, as well as what to do if the deadline is missed
- The telephone number of the QIO to request the appeal

The date when the information is verbally communicated is considered the NOMNC's receipt date. Providers must document the telephone contact with the member's representative on the NOMNC on the day that it is made, indicating that all of the previous information was included in the communication. The annotated NOMNC also should include:

- The name of the staff person initiating the contact
- The name of the representative contacted by phone
- The date and time of the telephone contact

- The telephone number called

A dated copy of the annotated NOMNC must be placed in the member's medical file, mailed to the representative the same day as the telephone contact, and faxed to the provider's local Humana health services utilization management department.

**Right to appeal a NOMNC (fast-track appeal):** CMS offers fast-track appeal procedures to Medicare members, including MMAI members, when coverage of their SNF, HHA or CORF services will soon end. CMS contracts with QIOs to conduct these fast-track appeals.

When notified by Humana or the QIO that the member has requested a fast-track appeal, SNFs, HHAs and CORFs must:

- Provide medical records and documentation to Humana and the QIO, as requested, no later than close of the calendar day on which they are notified. This includes, but is not limited to, weekends and holidays.
- Deliver the Detailed Explanation Non-Coverage (DENC) Form provided by Humana (or delegated to the provider for completion) to members or their authorized representatives no later than close of the calendar day on which they are notified, including on weekends and holidays. The DENC provides specific and detailed information concerning why the SNF, HHA or CORF services are ending.

If a member misses the time frame to request an appeal from the QIO, the member still can appeal through Humana's appeals department.

For more information about notification of termination requirements, providers can visit the **CMS website**.

# Emergency service responsibilities

## Emergency services

Participating providers are required to ensure adequate accessibility for healthcare 24 hours per day, seven days per week. An after-hours telephone number must be available to members. Voicemail alone is not acceptable.

Members should go to the closest emergency room or any other emergency setting if they experience symptoms including, but not limited to, 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

If the member is treated and stabilized during an emergency visit, and the treating doctor recommends continued treatment, the member is instructed to call their Humana PCP. Members who suffer an emergency while away from home are instructed to go to the nearest emergency room or setting. In such situations, the member's PCP should be contacted as soon as possible.

## Emergency mental health services

For behavioral health services, please instruct members to call Humana at **855-371-9234**.

For emergency behavioral healthcare, please instruct members to go to the nearest hospital emergency room or any other recommended emergency setting. Emergency behavioral health conditions include, but are not limited, to:

- Becoming a danger to themselves or others
- Being unable to carry out actions of daily life due to so much functional harm
- Threat of serious harm to the body that may cause death

# Model of care and care coordination

## Overview of the CMS-approved model of care

Humana's model of care program provides a proactive and comprehensive system of member care for those living with chronic physical diseases, mental illness, substance use disorders and/or developmental and intellectual disabilities. The program is designed to promote person-centered, integrated care across the spectrum of medical, behavioral, psycho-social and long-term services and supports. It is aimed at eliminating fragmented and often poorly coordinated healthcare and social services that historically plague the effective member treatment and result in poor health status and ineffectual expenditures.

In addition to focusing on the member experience, Humana's model of care provides appropriate utilization of services and ensures cost-effective health services delivery.

The provider's participation is key and includes the following activities:

- Participation in Interdisciplinary care team (ICT) care conferences via phone, through exchange of written and, possibly, in-person communications
- Participation in inbound and outbound communications to foster care coordination
- Promote Healthcare Effectiveness Data and Information Set (HEDIS®) and National Committee for Quality Assurance (NCQA) quality measures
- Provide all medical record documentation and information as requested to support Humana's fulfillment of state and federal regulatory and accreditation obligations (e.g., HEDIS)

## Continuity of care

Humana offers an initial 180-day transition period for new Demonstration members to maintain a current course of treatment with an out-of-network provider. Humana offers a 90-day transition period for members transitioning to Humana from another Demonstration plan. The 180- and 90-day transition periods are applicable to all providers, including behavioral health providers and LTSS providers. Non-participating PCPs and specialists providing an ongoing course of treatment will be offered single-case agreements to continue member care beyond the transition period if they remain outside the network or until a qualified, affiliated provider is available.

Providers' roles and responsibilities in care coordination, care transitions, comprehensive medication reviews and preventive screenings include:

- Delivering evidence-based medical management addressing member needs, choices and cultural preferences
- Ensuring that members are informed of specific follow-up healthcare needs and that members receive training in self-care that includes medication adherence and other measures that promote member health
- Ensuring members receive necessary appropriate specialty, ancillary, emergency and hospital care
- Providing necessary referrals and communication to specialists, hospitalists, SNFs and other providers
- Providing information that assists in member understanding and choice regarding consultation and recommending treatments, equipment and/or member services
- Providing coordination of care for members who are homebound or have significant mobility limitations to ensure access to care through home visits by nurse practitioners or physicians
- Tracking and documenting member appointments, clinical findings and treatment plans to ensure continuity of care from referred specialists, other healthcare providers or agencies
- Obtaining authorizations and notify Humana of any out-of-network services when a participating specialty provider is unavailable in the geographic area
- Arranging, with Humana's care coordination team, for member-requested second opinion examinations with qualified in-network healthcare professionals.
- Providing member help with arrangement for a second opinion visit with a non-participating provider, if no in-network provider is available
- Initiating or assisting with member discharge or transfer from an inpatient facility to the most medically appropriate level of care facility or the member's permanent home
- Considering availability of in-network facilities and obtain appropriate authorizations if using out-of-network facilities

- Cooperating and communicating with other member service providers. Such providers may include Supplemental Nutrition Programs for Women, Infants and Children (commonly referred to as WIC programs), Head Start programs, early intervention programs and school systems. Such cooperation may include performing annual physicals for school and sharing information with member consent.
- Supporting and communicating with the ICT (in person and/or writing) in developing and implementing an individualized plan of care to facilitate effective care coordination
- Providing timely access to medical records or information for quality management and other purposes, including audits, reviews of complaints or appeals, HEDIS and other studies, and promptly respond to recommendations for improvement by developing and enacting a corrective/improvement plan, as appropriate
- Following the preventive care guidelines set by the U.S. Preventive Services Task Force, and providing and document the preventive care services required by the NCQA for HEDIS Quality Assurance Reporting Requirements
- Acknowledging that out-of-network or other authorizations are limited to the terms of the authorization as part of the member's ongoing course of treatment in accordance with continuity-of-care guidelines consistent with state requirements
- Adhering to preauthorization and referral processes and procedures
- Transmitting a member's transition record (discharge instructions) within 24 hours of discharge from an inpatient facility to the facility, PCP or other healthcare professional designated for follow-up care, including the diagnosis, treatment and care plan

**NOTE:** For members other than those who reside in nursing facilities:

- Members maintain their current providers for 180 days from the effective enrollment date, or 90 days if changing health plans
- During the 180-day transition period, the member's existing provider may be changed, but only if:
  - The member requests a change.
  - The provider chooses to discontinue providing member services as currently allowed by Medicare or Medicaid.
  - Humana, CMS or the state identifies provider performance issues that affect a member's health and welfare.

## Care coordination requirements for out-of-network providers

Out-of-network providers must agree to:

- Accept reimbursement at Humana's established rates based on a review of the level of services provided
- Adhere to Humana's QA requirements
- Provide necessary medical information related to healthcare
- Adhere to Humana's policies and procedures, including procedures regarding referrals

If the physician of a new member in the midst of an active, ongoing course of treatment or in the third trimester of pregnancy is not a participating provider, Humana will permit the member to continue receiving treatment with that physician for up to 90 days or through the postpartum period, or as otherwise required by Section 25 of the Managed Care Reform and Patients' Rights Act (only if the out-of-network physician agrees to provide the ongoing course of treatment).

## Provider creation and participation in individualized care plans

The individualized care plan (ICP) is based on:

- Initial and ongoing health risk assessments (HRAs) and comprehensive assessment results
- Claims history
- ICT-developed member plans
- Inclusion of member-driven short and long-term goals, objectives and interventions
- Addressing of specific services and benefits
- Provision for measurable outcomes

The ICT is a team of caregivers from different professional disciplines who work together to deliver care plan services that optimize quality of life and support of the member and their family.

Provider participation is an integral part of the ICT. Other team members may include:

- The member and/or their authorized caregiver
- The member's physicians and/or nurses

- Humana's care coordinators
- Social workers and community social-service providers
- Humana's and/or the member's behavioral health professionals
- Humana's community health educators and resource-directory specialists

The physician-inclusive ICT model supports the following:

- Physician treatment and medication plans
- Physician goals via the Humana care management team of nurses, social workers, pharmacy and behavioral health specialists
- Member education and enhancement of direct patient-physician communication
- Self-care management and informed healthcare decision-making
- Care coordination and care transitions
- Access and connections to additional community resources
- Coordination of Medicare and Medicaid benefits and services, including LTSS
- Appropriate advance illness and end-of-life planning

Illinois law allows for the following two types of advance directives: designation of a healthcare power-of-attorney and creation of a written healthcare directive, also known as a living will. Providers should ensure members are informed of these rights.

Expected provider communications and reporting responsibilities:

- Maintain frequent in-person or phone communication with the ICT (and other providers of care and services such as specialist physicians, hospitals and/or ancillary providers) to ensure continuity of care and effective care coordination.
- Immediately report actual or suspected child and elder abuse or domestic violence to the local law enforcement agency by telephone and submit a follow-up written report within the time frames as required by law.
- Provide all requested medical record documentation and information to support Humana's fulfillment of state and federal regulatory and accreditation obligations, e.g., HEDIS and NCQA, including applicable access to electronic health records.

**NOTE:** Additional member information will be added regarding care plans, assessments and member summaries and made available through **Availity**.

When working with Demonstration members with a mental health diagnosis:

- Facilitate appropriate member referral to specialists or specialty care, behavioral healthcare services, health education classes and community resource agencies.
- Integrate medical screening along with basic primary care services provided to Demonstration members
- Provide screening and evaluation procedures for referral, detection and treatment of any known or suspected behavioral health problems and disorders
- Deliver evidence-based behavioral health treatment and establish referral protocols for behavioral health specialty providers
- Ensure confidentiality of members' medical and behavioral health and personal information as required by state and federal laws

Multiple chronic conditions increase the risks for poor outcomes such as mortality and functional limitations as well as the risk of high-cost services such as hospitalizations and emergency room visits. Evidence proves that preventive care and frequent/consistent care of chronic conditions lowers the advent of major conditions and decreases use of emergency room visits and readmissions.

Humana's Clinical Practice Guidelines, available to both affiliated and non-affiliated providers on Humana's website at Humana.com/providers, incorporate relevant, evidence-based medical and behavioral health guidelines (preventive and certain non-preventive acute and chronic conditions) from recognized sources such as professional medical associations, voluntary health organizations and NIH centers and institutes.

Humana provides chronic disease management services and support to promote self-management for individuals with chronic conditions.

When coordinating both Medicare and Medicaid benefits, including information on LTSS Medicaid benefits, please keep in mind:

- Member-centered, coordinated care – person-centered and collaborative care, managed by a team with knowledge about specific member needs and the array of medical, non-medical and behavioral services and benefits available to meet those needs – is critical to helping members achieve their optimum level of wellness.
- Many dual-eligible members require a broad range of LTSS and community support to meet their functional needs. Effective coordination, administration of and easy access to LTSS benefits help ensure that these needs are adequately met and reduces the reliance on less appropriate and more costly emergency or hospital-based care.
- Demonstration members are faced daily with a variety of life challenges. Humana aims to eliminate the challenges and frustration of navigating a complex healthcare system by integrating a variety of administrative processes for members and providers.

# Provider disputes

## Provider disputes submitted to Humana

If, after receipt of an initial claim determination from Humana via an Explanation of Remittance, Automated Remittance Advice, or Remittance Advice, providers disagree with the determination made by Humana, they may request a dispute/reopening of the issue.

## Non-behavioral health provider disputes

Providers may submit disputes online or by contacting Humana via telephone, written correspondence or fax.

### Online

Provider disputes about finalized claims can be submitted online via Availity Essentials. To begin, use the Claim Status tool to locate the claim and select the "Dispute Claim" button. Then go to the request in the Appeals worklist (located under Claims & Payments) to supply needed information and documentation and submit the request to Humana. Status and high-level Humana determination for disputes submitted online can be viewed in the Appeals worklist. For training opportunities, visit **Humana.com/ProviderWebinars**.

### On the phone

Provider disputes may be submitted telephonically by calling 800-787-3311, Monday through Friday, 7 a.m. and 7 p.m., Central time. Follow the prompts until you can provide the claim ID for the claim that you would like to dispute, and then you may request to file a claim dispute. You are then transferred to a specialized associate who can assist you.

### On paper

Send written disputes to:
Humana Provider Correspondence
P.O. Box 14601
Lexington, KY 40512-4601

Provider disputes may also be submitted via fax to **888-556-2128**.

Please note, provider disputes containing a request for reconsideration should include the following documentation:

- A copy of the original claim
- The remittance notification showing the denial
- Any clinical records and other documentation that support your case for reimbursement

Humana is required to assign the provider a MCO tracking number for each complaint submitted through the Humana internal dispute process. Disputes submitted telephonically may not generate a tracking number if the dispute is resolved during the call. However, disputes submitted online, via mail or fax always generate a reference number. Please note, to account for required system generation timelines for disputes submitted via fax or online, please allow two to three business days for a tracking number to be generated prior to calling Humana if you are unable to locate an MCO tracking number.

Humana's MCO tracking number consists of a 12- to 13-character alphanumerical code. If you do not know or are unable to locate the MCO tracking number, please call Humana Provider Services at **800-787-3311** Monday through Friday, 7 a.m. – 7 p.m. Central time. Once the case is located, the Humana Provider Services representative will give you the tracking number.

In addition, refer to the outcome letter (sample below) that Humana sends in response to the claim dispute. Find the MCO tracking number—identified as "Reference ID"—in the header of the outcome letter.

Humana.

[DATE]

N/A N/A
1234 LOOKUP LANE
TAMPA FL 33611

| | |
|---|---|
| Patient name: | John Doe |
| Member ID number: | H0000000 |
| Group number: | xxxx |
| Claim number(s): | 987654321 |
| Patient date of birth: | 01/01/0001 |
| Reference ID: | 0123456789 |
| Reference ID: | 123456789 |
| Humana entity: | hmp |
| Account number: | 0000 |
| Provider name: | N/A |

## Behavioral health provider disputes

Providers can submit disputes for behavioral health claims by contacting Carelon via telephone, email, or fax.

### Telephonic

Provider disputes can be submitted telephonically by calling **855-481-7044** Monday through Friday, 7 a.m. – 5 p.m., Central time.

### Email

Provider claim disputes can be submitted in writing to WoburnClaimAppeals@carelon.com along with any supporting documentation.

### Fax

Provider disputes can be submitted via fax to **305-722-3013**.

Telephonically submitted disputes will not automatically generate a reference number if Provider Relations can address the provider's complaint while on the phone. However, a complaint tracking number can always be provided to the provider if requested.

For disputes received via email, Provider Relations will respond back to the provider with the MCO tracking number.

If a dispute is received via fax and includes the provider phone number, Provider Relations will call the provider with the MCO tracking number. If a phone number was not included, Provider Relations will send a fax acknowledging the receipt of the faxed dispute and include the MCO tracking number.

The reference number for behavioral health related complaints includes 15 numbers, separated by a dash after the eighth digit.

If you do not know or cannot locate the MCO tracking number for a dispute regarding a behavioral health claim, call Carelon Provider Services at **855-481-7044**. Once the case is located, the Provider Services representative will give you the MCO tracking number.

In addition, refer to the complaint acknowledgement letter that was sent in response to the claim dispute. Find the MCO tracking number (reference ID) in the header.

**Subject: Claims appeal acknowledgment**

Dear Provider:

Thank you for taking the time to contact us. We appreciate the quality care you provide our members.

We received your appeal on <<Received Date>> regarding the <<complete - partial denial>>of <<level of care- service type>>services for the above-referenced member.

Carelon Behavioral Health, Inc. is in the process of evaluating your request and supporting documentation. We will issue our determination within 30 days of the date of receipt of your request.

Sincerely,

Appeals Department
Carelon Behavioral Health, Inc.

## Provider disputes submitted to the Illinois Department of Healthcare and Family Services (HFS)

Providers can submit complaints regarding unresolved issues with Humana via the **HFS Managed Care Provider Resolution Portal**. Humana is responsible for the timely and complete resolution of provider complaint tickets that are uploaded to the HFS Provider Resolution Portal.

Disputes cannot be submitted through the HFS provider portal earlier than 30 calendar days after submitting the complaint to Humana, nor can they be submitted any later than the following:

- 30 calendar days after unsatisfactory resolution, and/or
- 60 calendar days after the provider submits the dispute to Humana for internal resolution

All HFS Managed Care Provider Resolution Portal submissions must include the MCO-assigned tracking number and the date the complaint was filed with Humana's internal dispute resolution process. The provider must enter this MCO-assigned tracking number in the portal when submitting the complaint ticket. If applicable, include the date that you received the MCO resolution. The HFS provider portal shares the dispute with Humana. Humana has 30 calendar days from the complaint receipt date to issue its written proposal to resolve the dispute, unless HFS grants a 30-day extension to Humana. Providers are notified if an extension is granted via the portal.

Providers must use the new standard complaints/claims-issue template when submitting two or more of the same or similar complaints with Humana. Providers are limited to a maximum of 100 similar complaints/claims on a template. When submitting a template, providers should not mix complaints/claims from different MCOs or different providers/facilities. Separate complaints/claims should be filed, with separate templates for each unique provider/facility (by Medicaid tax ID and location address).

Humana communicates directly with the provider to address the issue. When Humana requests additional information from a provider, the provider must provide the additional information or demonstrate that this information was already provided to Humana. Providers receive a final decision from Humana within 30 days of complaint submission via the portal. Incomplete complaints or lack of response by the provider cause the complaint to be closed in the portal.

If complaints cannot be resolved, the provider may request that HFS review and make a final decision. The HFS decision on all disputes is final.

# Grievance and appeals system

The section below is taken from Humana's Member Grievance and Appeals procedure as set forth in the Humana Member Handbook. This information is supplied to you to help you assist Humana members with this process, if requested. Please contact your network management consultant with questions about this process.

Humana representatives manage all member grievances and appeals. Humana keeps records of all grievances and appeals for 10 years, with the reason, date and results.

## Filing a grievance or appeal

Members with plan questions or issues can call Member Services at 800-787-3311. Members can file a grievance when they are dissatisfied with Humana or any aspect of care. An appeal can be filed if the member disagrees with a coverage decision.

Grievances and appeals can be filed orally or in writing.

A provider or other authorized person may help the member during the grievance or appeal process.

A written grievance or appeal must include:

- Member's name, address, telephone number and Humana member ID number
- Facts and details regarding the issue and the requested outcome
- Requestor's signature and date. If the requestor is not the member, additional documentation, such as a waiver or appointment of representative (AOR), may be required.

### Grievance

The member has the right to file a written or verbal grievance at any time. The grievance process may take up to 30 calendar days, but Humana resolves the member's grievance as quickly as required by the member's health condition. A letter advising the grievance outcome is sent to the member or authorized representative within 30 calendar days from the date Humana received the request.

### Appeal

The member has the right to file a written or verbal appeal within 60 calendar days of the date on the denial letter. The appeal process takes no more than 15 business days, but Humana resolves the appeal as quickly as the member's health condition requires. A letter advising the appeal outcome is sent to the member and the member's authorized representative within 15 business days from the date Humana received the request.

Humana may take an extension if more information is needed and the delay is in the best interest of the member. If an extension is taken, Humana has an extra 14 calendar days to make a decision. Humana sends the member a letter informing them of the extension and what to do if they disagree.

The member has the right to continue services during the appeal and Medicaid fair hearing process. If the member chooses to continue the services and the decision of the appeal is not in the member's favor, the member may have to pay for those services.

**NOTE:** The Humana appeal process must be exhausted before requesting a Medicaid state fair hearing.

### Expedited appeal process

The member, provider or authorized representative can request a verbal or written expedited appeal. If the member's life or health is in danger, the member or their authorized representative can file an "urgent" or "expedited" appeal. These appeals are handled within 24 hours of receipt of all the information required to work the appeal.

You can request an expedited appeal by calling Humana Provider Services at **800-787-3311 (TTY: 711)** Monday through Friday, 7 a.m. – 7 p.m., Central time.

If it is determined the appeal does not meet expedited criteria, it goes through the standard appeal process.

To send a grievance or appeal request in writing, please send it to:
**Humana Medical Plan Inc.**
Attn: Grievance and Appeals Department
P.O. Box 14546
Lexington, KY 40512-4546

Providers appealing a claim on behalf of a member may also do so online via **Availity Essentials**. To begin, use the Claim Status tool to locate the claim and select "Dispute Claim." Then go to the request in the Appeals worklist (located under Claims & Payments) to supply needed information and documentation and submit the request to Humana. You can view the status and high-level Humana determination for appeals submitted online in the Appeals worklist. For training opportunities, visit **Humana.com/ProviderWebinars**.

# Chronic and complex conditions

## Comprehensive diabetes care

**Diabetic retinal examinations** – Humana is committed to reducing the incidence of diabetes-induced blindness in Humana 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 PCP provides or manage services such that recipients with a history of diabetes will receive at least one funduscopic 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 diabetes' side effects. Glycohemoglobin is one-laboratory indicator of how well a member's blood sugar is controlled. Consistent with the American Diabetic Association recommendations, the Humana PCP provides or manages services such that members with a history of diabetes 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 PCP provides or manages services such that members with a history of diabetes receive annual lipid and lipoprotein determinations. If any anomalies are found in the annual baseline, additional studies should be conducted as medically necessary.

**Nephropathy** – The Humana PCP nephropathy screening is designed 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 manages the member by identifying evidence of a positive test for protein in the urine (micro- albuminuria testing). The member should be monitored for the disease, including end-stage renal, chronic renal failure and renal insufficiency or acute renal failure and referred to a nephrologist as needed.

**Congestive heart failure (CHF)** – Humana is aware that today there are effective options for treating heart failure and its symptoms. Humana recognizes that with early detection, symptoms can be reduced, allowing many patients with heart failure to resume normal, active lives. To further these goals, the Humana PCP provides or manages care of the member with CHF by prescribing and monitoring an 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 receive ongoing education of their disease.

**Asthma** – Humana recognizes that asthma is a common chronic condition that affects individuals of all ages. The PCP is expected to measure the member's lung function, assess condition severity and monitor the course of therapy based on the following:

- Member education about the contributing environmental control measures to avoid or eliminate factors that precipitate or exacerbate asthma symptoms
- Introduce comprehensive long-term pharmacologic management therapy
- Designed to reverse and prevent the airway inflammation characteristic of asthma, as well as pharmacologic therapy to manage asthma exacerbations
- 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, such as healthy body weight, moderate consumption of alcohol and regular exercise. PCPs are expected to document any confirmed diagnoses of hypertension in the member's medical record as well as assess and identify if the member is at risk for hypertension.

**HIV/AIDS** – Humana requires PCPs to assist members in obtaining necessary care in coordination with Humana Health Services staff. Please call Provider Services at **800-787-3311** or your provider contract representative for more details.

**HEDIS Care of Older Adult (COA) measures (MMAI program only)** – Humana recognizes that identification of issues related to medications, activities of daily living, and pain management are important evaluations for special needs members. The PCP is expected to assess the member's functional status assessment, current medications, preform a pain assessment and have a discussion regarding advanced care planning. The PCP also is expected to address any issues identified and make referrals to appropriate case management and/or disease management programs.

# Provider/subcontractor responsibilities

## Access to care

### MMAI Demonstration

Participating PCPs and specialists are required to ensure adequate accessibility for healthcare 24 hours per day, seven days per week. An after-hours telephone number must be available to members. Voicemail is not permitted. Members should be triaged and provided appointments for care within the following time frames:

- Urgent care – Member must be provided an appointment within one business day when medically necessary
- Routine sick member care – Member shall be seen within three weeks from the date of the request
- Well-care and routine visits – Member must be provided an appointment within five weeks of making a request
- Problems or complaints not deemed serious – Member must be provided an appointment within three weeks of making a request

Initial prenatal visits without expressed problems:

- First trimester – Member must be provided an appointment within 14 calendar days of the request.
- Second trimester – Member must be provided an appointment within seven calendar days of the request.
- Third trimester – Member must be provided an appointment within three calendar days of the request.

### Patient-centered medical home

Participating patient-centered medical homes (PCMHs) are required to manage and provide evidence-based services to members to integrate care with specialty and subspecialty practices. The medical home is required to adhere to the following:

- Enhance access and continuity. Accommodate member needs with access and advice during and after hours, give information to patients and their families about their medical home and provide members 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 members and their families with 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.

For more information on how your practice can become a PCMH, call Humana Provider Services at **800-787-3311**.

## Americans with Disabilities Act compliance

All Humana-contracted healthcare providers must comply with the Americans with Disabilities Act (ADA), and all applicable state and/or federal laws, rules and regulations. More details are available in the Humana provider agreement under “Compliance with Regulatory Requirements.”

Providers are required to comply with all ADA requirements, including:

- Use of waiting room and exam room furniture and accessible routes to and through rooms that meet needs of all members, including those with physical and nonphysical disabilities
- Use of clear signage throughout provider offices. Adequate handicapped parking also is required

If you have members who need interpretation services, either the provider or member can call the number on the back of the member ID card or visit Humana’s website at **Humana.com/accessibility-resources**.

To help our provider partners with this important requirement, Humana associates or associates of a designated vendor operating on behalf of Humana may perform physical inspection of provider office locations as one of the steps to help ensure required ADA compliance.

## Member special needs consideration

Providers must make efforts to understand the special needs of members. Member challenges may include physical compromises as well as cognitive, behavioral, social, and financial issues. Multiple comorbidities, complex conditions, frailty, disability, end-of-life issues, end-stage renal disease, isolation, depression, and polypharmacy are among daily challenges facing some members.

In recognition of those significant member needs, Humana incorporates all principles of either multi-disciplinary integration and person-centered care planning, coordination, and treatment into our care coordination program.

- Integrated care management is delivered within an ICT structure and holistically addresses the individual member.
- The member and/or authorized caregivers are maintained at the model-of-care core, which ensures person-centered and supported self-care.
- Each member is assigned a care coordinator who leads the member's ICT and links closely to the member's PCP. The coordinator's goal is to ensure that members get needed full-spectrum care that includes medical, behavioral health and long-term care services.
- Based on claims history and analytics, Humana's predictive model determines appropriate risk and intervention levels before channeling the member to the required level of coordination.
- A Health Risk Assessment (HRA) produces a clinically sound profile of the member's health status.
- The Health Risk Assessment provides an overall risk score that, when combined with the predictive model score, is used to direct interventions targeted to impactful concerns. The member is encouraged to participate in all aspects of care management and coordination, including in the development of an individualized care plan.
- The care coordinator and ICT ensure that the member receives any necessary assistance and accommodations, including those mandated by the ADA, to fully participate in care planning throughout the management process.

The team also assures that the member receives clear information about:

- Their health conditions and functional limitations
- How family members and social supports can be involved (as the member chooses) in member care planning
- Self-directed care options and assistance
- Opportunities for educational and vocational activities
- Available treatment options, supports and/or alternative courses of care

## Identifying care barriers encountered by the Demonstration population

- Different programs with diverse coverage and payment structures impact delivery of integrated care due to poor coordination of services and benefits, resulting in fragmented care that isn't focused on the member's needs.
- Shortage of health professionals in rural areas and inner cities affects Demonstration members' easy access to quality and cost-effective care and preventive services.
- Organizational barriers, including lack of interpreter services, wheelchair accessibility and long appointment wait times can cause frustration and potentially result in member refusal to seek and participate in care.
- Lack of coordination between behavioral health and other medical and non-medical services can cause care barriers.
- Cultural and religious beliefs impact member health beliefs and behaviors, including provider relationships and compliance to recommended treatments.
- Socioeconomic status may present issues related to poor education and lack of knowledge and support. The status affects a variety of concerns, such as awareness of available health options and support, reinforcement of healthy behaviors and ability to pay out-of-pocket.
- A member's lack of permanent residence can impact the ability of care providers to engage and provide member education and support.

## Family planning services

Any provider can provide family planning services to a member without preauthorization. In addition, providers should make available and encourage all pregnant women and mothers with infants to receive postpartum visits for voluntary family planning. The follow-up visit may include a discussion of all appropriate contraception methods, counseling and family planning services. Providers furnishing such family planning services to members must document the offering and provision of family planning services in the member's medical record. This provision should not prevent a healthcare provider from refusing to furnish any contraceptive or family planning service, supplies or information for medical or religious reasons.

## Preventive and clinical practice guidelines

These protocols incorporate relevant, evidence-based medical and behavioral health guidelines from recognized sources, including professional medical associations, voluntary health organizations and NIH Centers and Institutes. They help providers make decisions regarding appropriate healthcare for specific clinical circumstances. We strongly encourage

providers to use these guidelines and to consider these guidelines whenever promoting positive outcomes for clients. The provider remains responsible for ultimately determining the applicable treatment for each individual.
Use of these guidelines allows Humana to measure their impact on care outcomes. Humana monitors provider guideline implementation through claim, pharmacy and utilization data.

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

- Provider manual updates
- Provider newsletters
- Provider website

Providers also can receive preventive health and clinical practice guidelines through the care management department or their provider relations representative. Preventive guidelines and clinical practice guidelines also are available at **Humana.com/providers**.

## Domestic violence, alcohol and substance use, and smoking cessation

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

Members should be screened for signs of alcohol and substance use as part of a prevention evaluation:

- On initial member contact
- During routine physical examinations
- During initial prenatal contact
- When the member shows evidence of over-utilization of medical, surgical, trauma or emergency services
- When documentation of emergency room visits becomes necessary

Regarding smoking-cessation, PCPs should educate members by:

- Helping them recognize the dangers of smoking
- Teaching them how to anticipate and avoid temptation
- Providing basic smoking cessation information
- Encouraging them to quit and talk about the quitting process

## Change of provider data

Any change in a provider's name, address, telephone number or change of ownership needs to be reported without delay to Humana Provider Relations online through **Availity Essentials**.

# Quality improvement requirements

## Monitoring and evaluating quality

Humana monitors and evaluates the quality and appropriateness of (or failure to provide) member care and service delivery through:

- **Quality improvement projects (QIPs)** – Ongoing measurements and interventions that help spur significant improvement of care quality and service delivery in both clinical care and non-clinical areas known to have a favorable effect on health outcomes and member satisfaction
- **Medical record audits** – Annual medical record review conducted by an External Quality Review Organization (EQRO) to evaluate the quality outcomes concerning the timeliness of, and member access to, covered services
- **Performance measures** – Data on patient outcomes as defined by HEDIS or otherwise defined by the agency
- **Access to care audits** – Assembly of randomly selected provider pool to gauge providers' appointment availability and after-hours answering service and identify opportunities to improve appointment access
- **Surveys** – Consumer Assessment of Health Plans Survey (CAHPS) and Provider Satisfaction Survey
- **Peer review** – Conducted by Humana to review provider practice methods, patterns and appropriateness of care

If the quality improvement projects, CAHPS, performance measures, the annual medical record audit or the EQRO indicate unacceptable Humana performance, the agency may impose penalties.

## Provider requirements related to community outreach

Providers:

- May display health plan-specific materials in their own offices
- Cannot – outside of providing confirmation of health plan participation – compare benefits or provider networks among health plans (either orally or in writing)
- May announce a new or changing health plan affiliation and give their patients a list of health plans with which they contract
- May not make provider affiliation announcements that include marketing content
- Communication with the member will not be limited by Humana Medicare-Medicaid Alignment Initiative (MMAI)
- 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 advertisement
- Shall not furnish lists of their Demonstration-covered patients to the health plan with which they contract, or any other entity, or furnish other health plans' membership lists or provide assistance with enrollment to the health plan or assist with enrollment
- May distribute information about non-health-plan-specific state or local health, welfare and social services, but only if prospective member inquiries are referred to the health plan's member services department or the agency's choice counselor/enrollment broker.

## Illinois Medicaid provider number

All providers must have a unique state Medicaid provider number obtained after enrolling in the state's IMPACT program and are in accordance with the IMPACT agency guidelines.

## National Provider Identifier (NPI)

Providers are required to have a National Provider Identifier (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.

## Compliance-based training

Providers are expected to adhere to all Humana-identified compliance-based training programs. This adherence includes a completed attestation by all participating providers and staff members trained on compliance material. The training includes the following required annual training modules:

- Humana orientation
- Medicaid provider orientation
- Cultural competency
- Health, safety, and welfare education

- Fraud, waste and abuse and general compliance

Providers must complete these trainings annually and within 30 days of being contracted.

## How to access online training modules

Providers and their office staff can access these online training modules 24 hours a day, seven days a week via Availity Essentials at **Availity.com**. Providers also can manually complete the training by visiting **Humana.com/providercompliance**.

For additional provider training, visit **Humana.com/providers**.

**NOTE:** Directions for accessing general compliance and fraud, waste and abuse trainings can be found at **Humana.com/fraud**. Providers and their office staff can access these online training modules 24 hours a day, seven days a week.

For long-term services and supports and behavioral health providers, please see long-term services and supports and behavioral health sections of this manual for contact information and help in accessing this required training.

## Requirements regarding community outreach activities and marketing prohibitions

- In accordance with 42 CFR 438.104(b)(1)(iv), Humana and its subcontractors shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
- In accordance with 42 CFR 438.104 (b)(1)(v), Humana and its subcontractors shall not, directly or indirectly, engage in door-to-door, telephone, or other cold-calling marketing activities.
- In accordance with 42 CFR 438.104 (b)(2)(i), Humana and its subcontractors shall not directly make any assertion or statement (whether written or oral) that the beneficiaries must enroll with Humana to obtain Medicaid state plan benefits or to retain Medicaid state plan benefits.
- In accordance with 42 CFR 438.104 (b)(2)(ii), Humana and its subcontractors shall not make any inaccurate false or misleading claims that Humana is recommended or endorsed by any federal, state or county government, the agency, CMS, department or any other organization that has not certified its endorsement in writing to Humana.

## Medical record standards

For each MMAI member, the provider should maintain detailed and legible medical records that include:

- Member's identifying information including name, member ID, date of birth, sex and details of legal guardianship (if any)
- A summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications
- Description of chief complaint or purpose of visit, the objective diagnosis, medical findings of provider impressions
- Identification of any studies ordered and any referral reports
- Identification of any therapies administered and prescribed
- Name and profession of the provider rendering services, including the signature or provider initials
- Member disposition, recommendations and instructions and evidence of any follow-up and service outcomes
- Immunization history
- Information relating to the member's use of tobacco products and alcohol/substance use
- Summaries of emergency services, care and hospital discharges with appropriate follow-up
- Documentation of referral services and member medical records
- All services provided by provider (family planning services, preventive services, etc.)
- Primary language spoken by the member and any member translation needs
- Information indicating a member's need of communication assistance in the delivery of healthcare services
- Documentation that member was provided written member rights information that includes details on advance directives and confirmation that the member has received the advanced directive information

# Claims submission protocols and standards

## Submitting an electronic claim

Healthcare providers can use Availity Essentials and electronic data interchange (EDI) services as no-cost solutions for submitting claims electronically. To register for Availity Essentials or to learn more about Availity claims solutions, visit **Availity.com**.

Healthcare providers also can file a claim by EDI through the clearinghouse of their choice. Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for information.

If submitting a claim to a clearinghouse, use the following payer IDs for Humana:

- Claims: 61101
- Encounters: 61102

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:

| **Claims** | **Encounters** |
|---|---|
| Humana Claims Office | Humana Claims Office |
| P.O. Box 14601 | P.O. Box 14605 |
| Lexington, KY 40512-4601 | Lexington, KY 40512-4605 |

## Timely provider payments

For claim payment inquiries or complaints, please call Humana Provider Services at **800-787-3311** or contact your network management consultant.

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

Humana makes provider payments (including the fiscal agent making payments to personal assistants under the HCBS waivers for covered services) on a timely basis consistent with the claims payment procedure described in 42 U.S.C. § 1396a(a)(37)(A) and 215 ILCS 5/368a. Payment complaints or disputes for the provision of services are subject to Humana's provider dispute process.

Humana pays 90% of all clean covered provider service claims within 30 days following submission receipt. Humana pays 99% of all clean covered provider service claims within 90 days following submission receipt.

For member admission to a nursing facility, a clean claim means that the admission is reflected on the patient's credit file that Humana receives from the state.

# Cultural humility

Culture refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, values and institutions that unite a group of people.

"Cultural Competence" is the capability of effectively interacting with people from different cultures.

Cultural humility involves understanding the complexity of identities—that even in sameness there is difference, and focuses on self-reflection, encouraging ongoing curiosity rather than an endpoint of knowledge.

- Cultural humility in healthcare describes a lifelong commitment to self-evaluation and critique, to redressing power imbalances and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations. (Source: Tervalon, M., Murray-Garcia, J. "The Concept of Cultural Humility")
- Cultural competence encompasses behaviors, attitudes and policies that can come together on a continuum and ensures a system, agency, program or individual can function effectively and appropriately in diverse cultural interactions and settings. (Source: U.S. Department of Health and Human Services reference)

## Cultural considerations for healthcare encounters

Subculture is a term that describes ethnic, regional, economic or social groups that exhibit characteristic behavior patterns that distinguish them from others within an embracing culture or society. Understanding the many different subcultures that exist within our own culture is an important aspect of cross-culture healthcare.

To address health issues within different ethnicities, providers must work to understand the values, beliefs and customs of these different people. Some cultural aspects that may impact health behavior Include:

- Eye contact – Many cultures use deferred eye contact to show respect. Deferred eye contact does not mean the patient is not listening to you.
- Personal space – Different cultures have varying approaches to personal space and touching. Some cultures expect more warmth and hugging when greeting people.
- Respect for authority – Many cultures are very hierarchical and view doctors with a lot of respect. These patients may feel uncomfortable questioning doctors' decisions or asking questions.

Additional considerations for healthcare encounters include:

- Communication styles:
  - Example: In some cultures, direct communication is valued, while in others, indirect or non-verbal cues may be more significant. Understanding these nuances helps healthcare providers convey information effectively.
- Beliefs about health and illness:
  - Example: Traditional beliefs, such as the influence of spirituality or the preference for alternative medicine, can shape individuals' decisions about seeking and accepting medical care.
- Attitudes toward authority and decision-making:
  - Example: Some cultures prioritize shared decision-making, involving the patient and family, while others may place more emphasis on the authority of the healthcare provider.
- Perceptions of pain and suffering:
  - Example: Cultural variations in the expression and interpretation of pain may affect how patients communicate their symptoms and how healthcare providers assess and manage pain.
- Family dynamics:
  - Example: In certain cultures, family plays a central role in healthcare decisions. Understanding familial dynamics helps healthcare providers involve and respect the support systems around the patient.
- Healthcare practices and beliefs:
  - Example: Dietary preferences, traditional healing practices and health rituals can impact treatment adherence and the effectiveness of medical interventions.
- Language and health literacy:
  - Example: Language barriers can affect a patient's understanding of medical information, leading to potential misunderstandings or non-compliance with prescribed treatments.
- Cultural stigma and mental health:
  - Example: Stigmatization of mental health issues in some cultures may influence whether individuals seek help, affecting the diagnosis and treatment of mental health conditions.

## Clear communication

"Clear communication" involves effectively transmitting information in a way that is easily understood and respectful of diverse cultural backgrounds.

This includes:

- Language considerations:
  - Using plain language.
  - Avoiding medical jargon.
  - Providing translated materials when necessary.
- Understanding communication styles:
  - Recognizing variations in direct and indirect communication.
  - Being attentive to non-verbal cues and body language.
- Active listening:
  - Demonstrating attentiveness and empathy.
  - Encouraging patients to share their perspectives and concerns.
- Clarifying information:
  - Checking for understanding by asking open-ended questions.
  - Confirming that the patient comprehends medical instructions.
- Respecting cultural norms:
  - Being aware of cultural preferences regarding eye contact, personal space and touch.
  - Adapting communication styles based on cultural backgrounds.
- Tailoring information:
  - Customizing information to align with the patient's cultural beliefs and values.
  - Recognizing and addressing cultural health literacy levels.
- Involving interpreters:
  - Ensuring accurate interpretation for patients with limited English proficiency.
  - Utilizing professional interpreters to enhance communication.

Clear communication is essential for establishing trust, promoting patient engagement, and ensuring informed decision-making. It requires healthcare providers to be sensitive to cultural nuances, fostering a collaborative and respectful healthcare environment.

## Limited English proficiency

Limited English proficiency (LEP) describes how the degree to which a member's inability or a limited ability to speak, read, write or understand the English language affects interactions between the member and healthcare providers or Humana associates.

## Health literacy

Health literacy describes a member's ability to obtain, process and understand basic health information and services needed to make appropriate decisions. Over a third of patients experience limited health literacy, which results in a lack of understanding of what is required to improve their health.

Limited health literacy is associated with:

- Poor management of chronic diseases
- Poor understanding of and adherence to medication regimens
- Increased hospitalizations and poor health outcomes

Humana develops member communications based on health literacy and plain language standards per the federal Plain Writing Act of 2010. The reading ease of Humana written member materials is tested using the widely recognized Flesch-Kincaid Readability tool.

Health literacy is a critical aspect of effective healthcare delivery, encompassing the ability of individuals to access, comprehend, and apply health information to make informed decisions about their well-being. Healthcare providers play a pivotal role in promoting health literacy and ensuring optimal patient understanding.

Here are key considerations:

- Clear communication:
  - Use plain language: Avoid medical jargon and communicate in a clear, concise manner.

  - Assess comprehension: Confirm understanding by encouraging patients to ask questions and summarizing key points.
- Written materials:
  - Provide written information in plain language with clear formatting.
  - Use visual aids: Include diagrams or charts to enhance understanding.
- Active listening:
  - Encourage patients to express concerns and questions.
  - Demonstrate empathy and validate patient experiences to build trust.
- Cultural sensitivity:
  - Recognize diverse backgrounds: Be aware of cultural nuances that may influence health beliefs and practices.
  - Tailor communication: Adapt your approach to accommodate cultural preferences and languages.
- Technology accessibility:
  - Ensure digital resources are user-friendly for all literacy levels.
  - Provide guidance on navigating online health information responsibly.
- Informed consent:
  - Clearly explain procedures, risks and benefits using non-technical language.
  - Verify comprehension before obtaining consent.
- Collaborative decision-making
  - Engage patients in the decision-making process.
  - Discuss treatment options, addressing patient preferences and values.
- Health education programs:
  - Develop educational initiatives considering varying literacy levels.
  - Utilize multimedia tools to enhance engagement.
- Continual assessment:
  - Regularly assess health literacy levels of patient populations.
  - Adjust communication strategies based on individual needs.
- Team training:
  - Train healthcare staff on effective communication techniques.
  - Foster a culture of health literacy awareness within the healthcare setting.

By prioritizing health literacy, healthcare providers contribute to improved patient outcomes, increased patient satisfaction, and a more equitable healthcare experience for all individuals.

## Language Assistance Program for LEP members

Humana is committed to providing free language assistance services for our members with LEP.

This assistance includes:

- Free interpretation services for all languages. Providers may call Humana at the phone number listed on the member's Humana ID card to access interpretation services while the member is in the office
- Spanish versions of Humana's non-secure website and member materials
- TTY/TDD services
- Written translation of Humana documentation. Members can request translated materials by calling the customer service phone number on the back of their Humana ID card.

## Seniors and people with disabilities

Humana develops individualized care plans that include consideration of special and unique member needs in accordance with the Americans with Disabilities Act (ADA). People with disabilities must be consulted before an accommodation is offered or created on their behalf. Some considerations in treating seniors and people with disabilities include:

- Disease and multiple medications
- Caregiver burden/burnout
- Cognitive impairment and mental health
- Visual impairment
- Hearing impairment

- Physical impairment

# Member rights and responsibilities

Members rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and the Memorandum of Understanding (MOU) between CMS and the state.

## Member rights

- The right to be treated with dignity and respect
- The right to be afforded privacy and confidentiality in all aspects of care and for all healthcare information, unless otherwise required by law
- The right to be provided a copy of their medical records, on request, and to request corrections or amendments to these records (as specified in 45 C.F.R. part 164)
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition, functional status and language needs
- The right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment
- The right to have all plan options, rules and benefits fully explained (including through the use of a qualified interpreter, if needed)
- Access to an adequate network of primary and specialty providers who are capable of meeting member needs with respect to physical access, communication and scheduling needs. The providers are also subject to ongoing assessment of clinical quality including required reporting
- The right to receive a second opinion on a medical procedure and have the contractor (Humana) pay for the second opinion consultation visit
- The right to choose a plan and provider at any time, including a plan outside of the Demonstration, and have that choice be effective the first calendar day of the following month
- The right to have a voice in the governance and operation of the integrated system, provider or Humana
- The right to participate in all aspects of care and to exercise all rights of appeal. Members have a responsibility to be fully involved in maintaining their health and making decisions about their healthcare, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, members must:
  - Receive a comprehensive, in-person assessment on plan enrollment and participate in the development and implementation of an individualized care plan. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of member strengths and weaknesses and a plan for managing and coordination member care. Members or their designated representatives also have the right to request a reassessment by the interdisciplinary team and be fully involved in any such reassessment.
  - Receive complete and accurate information on their health and functional status by the interdisciplinary team
  - Be provided information on all program services and healthcare options, including available treatment options and alternatives, regardless of cost or benefit coverage, presented in a culturally appropriate manner, taking a member's condition and ability to understand into consideration.
- The right to designate a representative, if the member is unable to participate fully in treatment decisions. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
  - Before and during enrollment
  - Whenever potential or current member needs necessitate the disclosure and delivery of such information to allow the member to make an informed choice
  - That encourages caregiver or family member participation in treatment discussions and decisions
  - That explains and encourages advance directives, if the participant so desires, in accordance with 42 C.F.R. §§489.100 and 489.102
  - That provides reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.
- Be afforded the opportunity to file an appeal if services are denied that they think are medically indicated, and to be

able to ultimately take that appeal to an independent external system of review
- The right to voice complaints or submit appeals about the organization or the care it provides
- The right to receive medical and non-medical care from a team that meets the beneficiary's needs, in a manner that is sensitive to the beneficiary's language and culture, and in an appropriate care setting, including the home and community
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- The right to exercise their rights, and that the exercise of those rights will not adversely affect the way the contractor (Humana), its providers, the state or CMS provide or arrange for the provision of medical services to the member
- The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the orientation materials at least once each year, and the right to receive notice of any significant information changes to orientation materials at least 30 days prior to the intended effective date of the change. See 438.10(g),(h)
- The right to be protected from liability (balanced billing) for payment of any fees that are the obligation of the contractor (Humana)
- The right not to be charged any cost sharing for Medicare Parts A and B services
- The right to make recommendations to the Enrollee Rights and Responsibilities statement

## Member responsibilities

- A member is responsible for providing to the healthcare provider, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to the member's health
- A member is responsible for reporting unexpected condition changes to the healthcare provider
- A member is responsible for notifying their PCP of any significant mobility limitations or homebound status that would warrant the need for PCP home visits
- A member is responsible for confirming their understanding of their health problems, a healthcare provider's possible course of action, member expectations and participating in developing mutually agreed-upon treatment plans to the best of their ability
- A member is responsible for following the healthcare provider-recommended treatment plan to which they agreed
- Members are responsible for notifying a healthcare provider or healthcare facility if, for any reason, they are unable to keep an appointment
- A member is responsible for their actions when refusing treatment or not following healthcare provider instructions
- A member is responsible for assuring that the financial obligations of their healthcare are fulfilled as promptly as possible

# Fraud, waste and abuse

## Introduction to fraud, waste and abuse

Both the federal government and the individual states that establish and monitor requirements for Medicare and Medicaid are trying to reduce fraud, waste and abuse (FWA) in the Medicare and Medicaid programs. Healthcare FWA can involve physicians, pharmacists, members and even medical equipment companies. Success in combating healthcare fraud, waste, and abuse is measured not only by convictions, but also by effective deterrent efforts.

## Reporting FWA

Anyone who suspects or detects a FWA violation is required to report it either to Humana or within their respective organization, which then must report it to Humana through one of the following methods:

**Telephonic**

Special Investigations Unit Hotline: **800-614-4126**

- Monday through Friday, 7 a.m. – 3 p.m., Central time
- Voicemail access: 24/7

Ethics Help Line: **877-5-THE-KEY (877-584-3539)**

**Mail**
**Humana Inc.**
Fraud, Waste and Abuse
1100 Employers Blvd.
Green Bay, WI 54344

Email and Web
Email: siureferrals@humana.com or ethics@humana.com
Web: Ethicshelpline.com or Humana.com

## Key features of methods for direct reporting suspected FWA to Humana

**Anonymity:** If the person making the report chooses to remain anonymous, they are encouraged to provide enough information on the suspected violation – i.e., date(s) and person(s), system(s), and type(s) of information involved – to allow Humana to review the situation and respond appropriately.

**Confidentiality:** Processes are in place to maintain confidentiality of reports; Humana allows confidential report follow-up. Humana strictly prohibits intimidation and/or retaliation against anyone who, in good faith, reports suspected or detected violation of ethical standards.

Additional information on this topic is included in the Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training document published by CMS.

**NOTE:** The concepts in the CMS document apply to all Humana lines of business. Please refer to Section I for more detailed information and directions regarding how to access this required annual training.

# Health safety and welfare

By law, providers must immediately report suspected abuse, neglect or exploitation risks to the appropriate state agency and the Humana member's ICT care manager.

This report includes, but is not limited to:

- **Abuse** – Non-accidental infliction of physical and/or emotional harm.
- **Physical abuse** – Causing the infliction of physical pain or injury.
- **Sexual abuse** – Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other disabled adult sexual activity: touching, fondling, sexual threats, sexually inappropriate remarks, or any other sexual activity with a person that 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 people to engage in conduct from which they wish and have a right to abstain, or to refrain from conduct in which they wish and have a right to engage.
- **Neglect** – Repeated conduct or a single incident of carelessness which results or could reasonably be expected to result in serious physical or psychological/emotional injury or substantial risk of death (this includes self-neglect and passive neglect).
- **Exploitation** – Illegal use of assets or resources of an adult with disabilities; including, but 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.

In most states, individuals who report these situations receive immunity from civil and criminal liability (unless the report was made in bad faith or with malicious intent) and identity protection, unless a court orders the reporter's identity revealed.

Additional information on this topic is included in Humana's required health, safety, and welfare education annual compliance training. Please refer to the information in Section I subsection Health safety and welfare for more detailed information and directions regarding how to access this required training.

# Section II: Long-term services and supports (LTSS)

As an LTSS professional, you play a very important role in the delivery of healthcare services to Humana members.

## Overview

- Humana bears the underwriting risk of all services covered under contract.
- Services are to be provided in accordance with an individualized care plan developed by Humana in consultation with the member and which includes services determined through an assessment by Humana to be necessary to address the health and service needs of the member.
- Humana may not require any copayment or cost sharing by members except the patient responsibility amount for nursing facility or supportive living facility services or any copayments established under state law for members of the Demonstration or the state's Medicaid program.
- Humana does not permit members to be charged for missed appointments.
- All services delivered to members by Humana's contractors (either directly or through a subcontract) must be guided by the following service delivery principles:
  - Services must be individualized as a result of a competent, comprehensive understanding of a member's multiple needs.
  - Services must be delivered in a timely fashion in the least restrictive, cost-effective and appropriate setting.
  - LTSS must be based on a member's plan of care and include goals, objectives and specific treatment strategies.
- Services must be coordinated to address comprehensive needs and provide continuity of care.
- Services must be delivered regardless of geographic location within the service area, function level, cultural heritage and degree of member illness.
- The project's administration and service delivery system must ensure member participation in care planning and delivery and, as appropriate, allow for the participation of family, significant others and caregivers.
- Humana must provide interpreter services (in-person, where practical, but otherwise by telephone) for members who do not speak English as a primary language. Annual agency-provided non-English versions of materials are required if the county population that speaks a particular non-English language exceeds 5%.
- Services must be delivered by qualified providers as defined by applicable contract.
- All facilities providing member services must be accessible to persons with disabilities, be smoke free and have adequate space, supplies, adequate sanitation and fire and safety procedures, per federal, state and local laws and regulations.

Managed care is an important part of enrolled member care coordination and service integration. The state contracts with Humana for a program offering various features to the Medicaid consumer who is at risk of placement in a nursing home, or otherwise meets a Medicaid program qualification. Humana uses LTSS providers including supportive living facilities, adult day care, skilled nursing facilities, home health and personal care organizations in their network.

The Provider Relations Department is responsible for provider education, recruitment, contracting and new provider orientation. The Quality Management Department is responsible for monitoring quality and regulatory standards, and investigation of member complaints and grievances. The Provider Data Management Department presides over coordinating contract loads, demographic changes and provider terminations in the provider data management system.

The Provider Relations Department offers our network partners an array of provider services that includes initial provider orientation and education. These sessions are hosted by Provider Relations representatives and available in-person, in group settings and through webinars.

# Covered services

## General services

Through its contracted providers, Humana is required to arrange for medically necessary services for each member. When providing covered services to plan members, the provider must adhere to applicable plan coverage provisions and all applicable state and federal laws.

**Table 2-1 LTSS-covered services**

**Waiver eligibility required; $0 member cost; Prior authorization and referral may be required**

### Adult day services

**Covered services:** Adult day service provides direct care and supervision of adults age 60 and older in a community-based setting for the purpose of providing personal attention and promoting social, physical and emotional well-being in a structured setting. Available for members on the following waivers:

- Persons who are elderly
- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

### Adult day service transportation

**Covered services:** Provision or arrangement for transportation, with at least one vehicle physically accessible, to enable members to receive adult day service at the adult day service provider's site and participate in sponsored outings.

No more than two one-way trips of transportation shall be provided per participant in a 24-hour period, and shall not include trips to a physician, for shopping or other miscellaneous trips.

Available for members on the following waivers:

- Persons who are elderly
- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

### Automated Medication Dispenser

**Covered services:** Automated Medicaid dispenser (AMD) is a portable, mechanical system for individual use that can be programmed to dispense or alert the member to take non-liquid oral medications through auditory, visual or voice reminders; to provide notification of a missed medication dose; and to provide 24-hour technical assistance for AMD service in the member's home.

Available for members on the following waivers:

- Persons who are elderly

### Behavioral services

**Covered services:** Therapy services designed to assist members with brain injuries manage behavior and cognitive functions and enhance their capacity for independent living.

Available for members on the following waivers:

- Persons with brain injuries

### Environmental Accessibility Adaptations – Home

**Covered services:** Those physical adaptations to the home, required by the MemberCare Plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct remedial benefit to the member.

Vehicle modifications (wheelchair lifts and tie downs) are also provided under environmental modifications.

Available for members on the following waivers:

- Persons who are elderly

### Habilitation – Day

**Covered services:** Day habilitation assists with the acquisition, retention or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. The focus is to enable the individual to attain or maintain their maximum functional level.

Day habilitation shall be coordinated with any physical, occupational or speech therapies listed in the Member Care Plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy or other settings.

Available for members on the following waivers:

- Persons with brain injuries

### Home-delivered meals

**Covered services:** Prepared food brought to the member's residence that may consist of a heated luncheon meal and/or a dinner meal which can be refrigerated and eaten later.

This service is designed primarily for members who cannot prepare their own meals but can feed themselves. Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

### Home health aide

**Covered services**: Service provided by an individual that meets Illinois licensure standards for a certified nursing assistant (CNA) and provides services as defined in 42C.F.R. 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid State Plan are not applicable. Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

### Home modifications

**Covered services:** The modifications must be designed to ensure the member's health, safety and welfare or make the member more independent in their home. Modifications may include:

- Ramps
- Grab bars
- Doorway widening

Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

### Homemaker

**Covered services:** Homemaker service is defined as general non-medical support by supervised and trained homemakers. Homemakers are trained to assist individuals with activities of daily living, including personal care, as well as other tasks such as laundry, shopping and cleaning. The purpose of providing homemaker service is to maintain, strengthen and safeguard the functioning of members in their own homes in accordance with the authorized Enrollee Care Plan (also known as in home care). Available for members on the following waivers:

- Persons who are elderly
- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

### Nursing – Skilled (focus on short-term, acute healing needs)

**Covered services:** Home based, skilled-nursing services designed to help restore and maintain the highest member function and health levels.

These services are provided instead of a hospitalization or a nursing facility stay. A doctor's order is required.

Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

### Nursing – Intermittent (focus on long-term needs)

**Covered services:** Services include weekly insulin syringe or medicine dosage setup for members unable to manage these tasks themselves.

These services are provided instead of a hospitalization or a nursing facility stay. A doctor's order is required.

Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

### Personal assistant

**Covered services:** Services that involve the hiring and management of an in-home caregiver by the member. The member must be able to manage employer responsibilities, such as management of the caregiver's time and timesheets, and completing other employee paperwork. The caregiver helps with housekeeping and personal tasks such as:

- Eating
- Bathing
- Personal hygiene
- Daily living activities at home or at work (if applicable)
- Preparation of meals (not including cost of meals themselves)

Personal assistants can include other independent direct caregivers such as RNs, LPNs and home health aides. Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

### Personal Emergency Response System

**Covered services:** Personal emergency response system (PERS) is an electronic device that enables individuals to remain safe in their home and allows them to secure help in an emergency. The systems are connected to a phone and programmed to signal a response center in cases of an emergency.

Available for members on the following waivers:

- Persons who are elderly
- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

### Physical, occupational and speech therapy

**Covered services:** These services are designed to improve and/or restore a person's body function (includes physical therapy, occupational therapy and/or speech therapy).

Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

### Prevocational services

**Covered services:** These services are designed to provide work experiences, training and help in development of necessary general workforce skills. Includes teaching of concepts such as:

- Compliance
- Attendance task completion
- Problem-solving
- Safety

Available for members on the following waivers:

- Persons with brain injury

### Respite

**Covered services:** Respite services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the member.

Services are limited to personal assistant, homemaker, nurse, adult day care and provided to a member to provide their activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent.

Respite care services allow for the needed level of care and supportive services to enable the member to remain in the community, or home-like environment, while periodically relieving the family of care-giving responsibilities. These services are be provided in the member's home or in a Children's Community-Based Health Care Center Model, licensed by the Illinois Department of Public Health.

Services are available for a maximum of 240 hours per year.

Respite services are limited to:

- Personal assistant
- Homemaker
- Nurse
- Adult day care
- Activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent.

Available for members on the following waivers:

- Persons with brain injury
- Persons with disabilities
- Persons with HIV/AIDS

### Specialized medical equipment and supplies

**Covered services:** This service includes care plan-specific devices, controls or appliances that enable members to increase their ability to perform daily activities or perceive, control or communicate within their environment. Specialized medical equipment and supplies include:

- Devices
- Controls
- Appliances
- Items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan

Available for members on the following waivers:

- Persons with disabilities
- Persons with HIV/AIDS
- Persons with brain injury

### Supported employment

**Covered services:** Services involve activities needed to maintain paid work by individuals receiving waiver services, including supervision and training.

Available for members on the following waivers:

- Persons with brain injury

**Supportive Living Program**

**Covered services:** An assisted-living housing option that provides members with many support services needed to keep the member as independent as possible.

Service examples include:

- Housekeeping
- Personal care
- Medication oversight
- Ancillary services
- Social programs

The program does not offer complex medical services or supports. Available for members on the following waivers:

- Supportive living facility

## Out-of-network care for unavailable services

After notification of authorization from a referring provider, Humana arranges out-of-network care if unable to provide necessary covered services or ensure the second opinion of a participating network provider.

## Value-added benefits

Value-added benefits are those offered by Humana and approved in writing by the state. Such services are included in the benefit summaries above. For additional information, providers can call the customer service number provided on the back of the Humana member's ID card.

## Care coordination and service authorization

LTSS service authorizations are created by the LTSS Utilization Management team. Requests for authorizations for Personal Emergency Response Services (PERS) must be submitted through the LTSS team by either contacting the Care Coordinator (CC) or making a request by emailing **HumLTSStransitions@humana.com**.

The CC completes a comprehensive assessment and works with the member to identify care needs and identify resources to meet those needs. The CC creates the LTSS service plan during the visit. If care needs exceed the state-provided service cost maximums, then the service authorization request is sent to the LTSS management team for further evaluation and review for medical necessity based on member care needs. Service denials or reductions are issued from the medical director. Providers can request LTSS services but all service authorization additions or changes must go through the care coordinator and be based on member assessment of needs. Providers can email Humana LTSS care coordinator at **HumLTSStransitions@humana.com** to request LTSS services on behalf of a Humana-covered member.

# Provider definition and status

The requirements for eligible providers of covered services are identified in the state Demonstration contract. Only licensed providers are eligible to provide services to plan members. Humana works with the guidelines and policies designed with the welfare and well-being of the member in mind.

The guidelines are designed to assist Humana in determining acceptance of facilities and other providers as network participants. In addition, the guidelines help ensure consistency, accuracy and timeliness of credentialing across all Humana sites and provide a tool to perform facility credentialing.

Further, during a statewide or national emergency, healthcare organizations wish to do whatever it takes to provide critical services to citizens in need. Therefore:

- Any licensed LTSS provider may be authorized to provide voluntary services during an emergency, regardless of whether they have previously been contracted.
- To verify license status of a LTSS provider, online resources or a copy of the license may be used.

## Provider contracting, application and credentialing

The LTSS provider has the responsibility of providing the necessary items for contracting.

All LTSS participating providers must be credentialed/registered with the state of Illinois through the IMPACT system prior to their contract effective date with Humana and re-credentialed/maintain active eligibility as the state requires. The provider contracting and credentialing policy is available through the Humana provider relations representative.

**NOTE:** General provider credentialing requirements can be found through the **state's IMPACT website**.

Noted time periods:

- Applications must be completed within 180 days of receipt of provider signature.
- If a letter of agreement is used, it will have an expiration date and need to be replaced by full application and agreement.
- Out-of-network or other authorizations are limited to the terms of the authorization.

# Provider policies and responsibilities

## Equal provider opportunity

Humana is an equal opportunity organization. Provider participation decisions are non-discriminatory and based on merit and business needs, not race, color, citizenship status, national origin, ancestry, gender, sexual orientation, age, weight, religion, creed, physical or mental disability, marital status, veteran status, political affiliations or any other factor protected by law.

## Affirmative Action, diversity and the Cultural Competency Plan

We are committed to embracing diversity in the provision of member services and providing fair and equal opportunities for all qualified minority businesses. Humana tracks and reports information to applicable agencies regarding utilization of certified and non-certified minority contractors and vendors for all subcontractors and vendors receiving funds pursuant to all covered contracts. Humana aims to accommodate religious and cultural preferences of all members and seeks provider input that might be useful in meeting member preferences.

To request a paper copy of Humana's Cultural Competency Plan, please call Humana Customer Service at **800-4HUMANA (800-448-6262)** or call your provider contracting representative. The copy of Humana's Cultural Competency Plan is provided at no charge to the provider.

By incorporating the following key elements, healthcare providers can create an environment that not only meets the diverse needs of patients, but also fosters a workplace culture that values and celebrates diversity at every level.

- Policy statement:
  - Clearly articulate a commitment to affirmative action, diversity and cultural competency in healthcare delivery.
  - Emphasize equal opportunity, inclusion and respect for diverse perspectives.
- Leadership commitment:
  - Ensure leadership actively supports and champions diversity initiatives.
  - Foster a culture that values and celebrates diversity at all levels of the organization.
- Workforce recruitment and retention:
  - Implement strategies to attract a diverse workforce, including underrepresented minorities.
  - Establish mentoring programs and career development opportunities to support retention.
- Training and education:
  - Provide ongoing cultural competency training for all staff, including healthcare providers.
  - Address unconscious bias and promote awareness of diverse healthcare needs.
- Patient-centered care:
  - Tailor care to meet the unique needs of diverse patient populations.
  - Implement language access services to ensure effective communication with all patients.
- Community engagement:
  - Actively engage with local communities to understand their specific healthcare needs.
  - Collaborate with community organizations to address health disparities and promote preventive care.
- Data collection and analysis:
  - Collect and analyze demographic data to assess workforce diversity and patient outcomes.
  - Use data to identify areas for improvement and track progress over time.
- Affirmative action plans:
  - Develop and implement affirmative action plans to address disparities in hiring and promotion.
  - Set measurable goals for increasing diversity and regularly evaluate progress.
- Inclusive policies and practices:
  - Review and update policies to ensure they are inclusive and do not inadvertently perpetuate bias.
  - Create a supportive environment for individuals of all backgrounds.
- Crisis response and emergency preparedness:
  - Develop plans that address the unique needs of diverse populations during emergencies.
  - Ensure that emergency communication is accessible to individuals with varying language abilities and cultural backgrounds.

- Feedback mechanism:
  - Establish channels for employees and patients to provide feedback on diversity and cultural competency initiatives.
  - Use feedback to continuously improve and refine the plan.

## Americans with Disabilities Act compliance

It is Humana's policy to comply with all the relevant and applicable provisions of the Americans with Disabilities Act (ADA). We will not discriminate against any qualified provider or job applicant with respect to any terms, privileges, or provider conditions because of a person's disabilities.

## Contract, law, and license compliance

Each provider application is contingent on verification of the candidate's right to provide services. Every provider is asked to provide documents that verify compliance.

## Provider background checks

A background check may be applicable depending on provider type and service. A comprehensive background check may include prior provider verification, professional reference checks, education confirmation, and verification that the provider is not on the Office of Inspector General list because providers on this list are ineligible for participation in Humana's network. Criminal record check and criminal allegations

Most provider licenses require a criminal record check be performed prior to license issue. If possible, Humana will not duplicate such effort, but reserves the right to request a criminal record check to protect our interests and those of our clients and members.

Any report that implies criminal intent on the part of provider and is referred to a governmental or investigatory agency must also be sent to the state Medicaid agency. Humana investigates allegations regarding falsification of client information, service records, payment requests and other related information. If Humana has reason to suspect the allegations have merit, they are referred as required by federal and state mandates.

## HIPAA standards

The task of handling member records and related administration functions is accomplished in strict compliance with the Health Insurance Portability and Accountability Act (HIPAA).
Member files will be kept confidential at all times.
Providers should take some or all of the following precautions:

- Only request and work with protected health information (PHI) related to "treatment, payment or healthcare operations."
- Email should not be used to transfer files with member info unless the email is encrypted.
- Fax machines should be positioned for privacy.
- Fax numbers should be confirmed before sending information to Humana.
- Leave minimum PHI on voicemail.

## Provider education of compliance-based materials

Providers are expected to adhere to all training programs identified by Humana as compliance-based training. This includes agreement and assurance that all participating providers and staff members are trained on the identified compliance material. This training includes, but is not limited to, the following training modules:

- Provider orientation
- Medicaid provider orientation
- Cultural competency (required annually)
- Health, safety and welfare education (required annually)
- Fraud, waste and abuse detection, correction and prevention (required annually)
- Critical incident reporting
- Abuse, neglect and exploitation
- Disability awareness and ADA
- Other Humana-specific training

For more information about:

- Humana's Cultural Competency Plan – Section I – General Provider Information
- Humana's Health, Safety and Welfare Training – Section I – General Provider Information
- Humana's Fraud, Waste and Abuse Training – Section I – General Provider Information

Additional information on these topics is included in Humana's required annual compliance training. For help in understanding how to access this required training, call Humana Provider Services at **800-787-3311 (TTY: 711)** Monday through Friday, 7 a.m. - 7 p.m., Central time, or visit **Availity.com** or **Humana.com/provider/news/provider-compliance**.

## Emergency service responsibilities

Humana has an emergency management plan that specifies what actions Humana conducts to ensure the ongoing provision of covered services in a disaster or man-made emergency, including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies.

Humana offers an after-regular-business-hours provider services line (not the prior authorization line) that is answered by an automated system that provides callers with information about:

- Operating hours
- Instructions for member enrollment verification
- Emergency or urgent medical conditions

This shall not be construed to mean that the provider must obtain verification before providing emergency services and care.

## Weather-related and emergency-related closings

At times, emergencies such as severe weather, fires or power failures can disrupt operations. In such instances, it is important that Humana be kept informed of your status. This is of real significance if you have an active authorization for a member. Resources may be found at the Illinois Emergency Management Agency website at **Illinois Emergency Management Agency**.

# Standards of conduct

## Stakeholder expectations

LTSS providers are problem-solvers and a member resource. LTSS providers contribute to positive member outcomes through reference to a care plan and member collaboration when addressing self-management and wellness issues. Stakeholders include:

- LTSS providers
- Humana
- The resident/member and their sponsors
- State and federal agencies and third-party healthcare providers

Humana is a resource for LTSS providers in meeting stakeholder expectations.

The Professional Case Management team is one heath plan benefit. The team develops a member care plan and makes appropriate care plan information available for LTSS provider use.

Your Humana agreement specifies appropriate service delivery scheduling guidelines in sections related to record keeping, policies and procedures and provider responsibilities attachments. The Humana agreement as a whole is relevant and referenced within the provider handbook. Please be sure to review.

Humana developed a monitoring process for service delivery scheduling versus actual member service wait times. When the service delivery scheduling or waiting times are excessive, Humana must take appropriate action to ensure adequate service delivery. Specific processes for ensuring adequate service delivery are outlined in your contract and explained during Humana orientation as applicable and appropriate for the services you provide.

## Reporting significant member health outcomes

Facility and home health providers must provide notice to Humana within 24 hours after an adverse event, such as member death, when a member decides to leave the facility against medical advice, and neglect, abuse, exploitation or fraud, which should be reported to regulatory authorities.
LTSS providers also should report member changes in health outcomes to the Humana case manager. Such adverse events include the following:

- Decline in member's health status due to medication management
- Significant worsening of activities of daily living (ADLs)
- Two or more behavioral health conditions
- Significant change in toileting ability
- Falls or accidents (with or without injury)

All adverse health outcomes reporting and reviews are part of quality initiatives.

## Critical incident reporting

Providers must agree to implement a systematic process for incident reporting and immediately (or no later than 24 hours after occurrence) notify Humana of any incident that may jeopardize the health, safety and welfare of a member or impair continued service delivery. Reportable conditions include, but are not limited to:

- Closure of provider services or facilities due to license violations
- Loss or destruction of member records
- Compromise of data integrity
- Fire or natural disasters
- Critical incidents or adverse events that affect a member's health, safety and welfare

The provider must ensure that members are free to exercise their rights, and that exercising those rights does not adversely affect how they are treated by providers, provider employees or affiliates.

**Compliance with other federal and state laws:** Providers must comply with all applicable federal and state laws, including: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality.

Helpful resources for critical incidents and adverse events:

- Children younger than 18: **800-25A-BUSE (800-252-2873)** or **TTY** at **800-358-5117**
  - Link to DCFS website with more information: http://www.illinois.gov/dcfs/safekids/reporting/Pages/index.aspx
- Members with disabilities who are age 18 and older, and seniors living in the community or if the ANE occurs in the community to a member living in a licensed facility: IDOA, Adult Protective Services (APS) at **866-800-1409** or **TTY** at **800-206-1327**.
  - Link to DOA for more information: http://www.illinois.gov/aging/ProtectionAdvocacy/Pages/abuse_reporting.aspx
- Members in nursing facilities: Department of Public Health's Nursing Home Complaint Hotline at **800-252-4343**
  - Link to IDPH for more information: http://www.dph.illinois.gov/topics-services/health-care-regulation/complaints
- Members aged 18-59 receiving mental health or Developmental Disability services in DHS operated, licensed, certified, or funded programs: DHS. Office of the Inspector General (OIG) at **800-368-1463** (voice and TTY)
  - Link to DHS website with more information: http://www.dhs.state.il.us/page.aspx?item=32675
- Members in Supportive Living Facilities (SLF): HFS' SLF Complaint Hotline at **800-226-0768**.
- Illinois Domestic Violence Victim Services Hotline: **877-TO-END DV** or **877-863-6338**. www.dhs.state.il.us/page.aspx?item=30275
- Office of Inspector General Medicaid/Welfare Fraud: **844-453-7283/844-ILFRAUD** https://www2.illinois.gov/hfs/oig/Pages/ReportFraud.aspx
- Illinois Helpline for Opioids and Other Substances: **833-234-6343**. www.Helplineil.org
- National Suicide Prevention Hotline: **800-273-TALK (8255)**. https://suicidepreventionlifeline.org/
- National Human Trafficking Hotline: **888-373-7888**. www.humantraffickinghotline.org

## Member transition to another network provider

Humana helps members transition to a new provider if their former provider leaves Humana's network both during and after the transition period is over. This policy is addressed in Humana's Care Coordination Policies and Procedures Manual.

**Table 2-2 Medicare-Medicaid Alignment Initiative (MMAI)**

| Waiver services | Department of Aging | Department of Human Services – Division of Rehabilitation Services | | | Healthcare and Family Services |
|---|---|---|---|---|---|
| | Elderly | Disability | HIV/AIDS | Brain injury | Supportive living facility |
| Adult day service | X | X | X | X | |
| Adult day service transportation | X | X | X | X | |
| Automated Medication Dispenser | X | | | | |
| Environmental accessibility adaptations - home | | X | X | X | |
| Supported employment | | | | X | |
| Home health aide | | X | X | X | |
| Nursing, intermittent | | X | X | X | |
| Nursing – skilled (RN and LPN) | | X | X | X | |
| Occupational therapy | | X | X | X | |
| Physical therapy | | X | X | X | |
| Speech therapy | | X | X | X | |
| Prevocational services | | | | X | |
| Habilitation-day | | | | X | |
| Homemaker | X | X | X | X | |

| Waiver services | Department of Aging | Department of Human Services – Division of Rehabilitation Services | | | Healthcare and Family Services |
|---|---|---|---|---|---|
| | Elderly | Disability | HIV/AIDS | Brain injury | Supportive living facility |
| **Home delivered meals** | | X | X | X | |
| **Individual provider, including personal assistant** (contingent on compliance with collective bargaining agreement and accompanying side letter between SEIU and the state). | | X | X | X | |
| **Personal Emergency Response System (PERS)** | X | X | X | X | |
| **Respite** | | X | X | X | |
| **Specialized medical equipment and supplies** | | X | X | X | |
| **Behavioral services (M.A. and Ph.D.)** | | | | X | |
| **Assisted living** – Nursing services, personal care, medication management, including administration, social and recreational programming, health promotion and exercise programs, 24-hour response/ security, emergency call system, daily checks, laundry, housekeeping, maintenance, ancillary services | | | | | X |

## Medical necessity standards and practice protocols

Medically necessary services are those that include medical allied, or long-term care, goods or services furnished or ordered to:

- 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.
- Meet guidelines pertaining to the treatment of chronic and complex conditions, including:
  - Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain
  - Be reflective of the level of safely furnished services and what equally effective and more conservative or less costly treatment is available statewide
  - Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational
  - Be furnished in a manner that does not give primary consideration to the convenience of the member, member's caretaker or the provider
- For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot 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, allied or long-term care goods or services does not, in itself, make such care, goods or services medically necessary or a covered service or benefit.
- Humana has protocols, policies and procedures for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies). Some may be incorporated herein, while others are identified in bulletins from Humana. Guidelines pertaining to the treatment of chronic and complex conditions are included in Humana bulletins.

## Humana implements MMAI Demonstration care plans

- The Humana care coordinator performs an assessment on each new member to determine necessary individual services and supplies and review the current plan of care.
- Once the needed services or supplies are identified, the Humana care coordinator finalizes the care plan. The Humana care coordinator and the LTSS provider may complete a type of care plan conference.
- Once the assessment and the care plan are completed, Humana sends an Agreed Services Form or copy of the service plan that identifies the member's care needs.

In accordance with Humana policy, it is the responsibility of the provider to submit all items necessary for claims processing.

# Claims submission protocols and standards

## Minimum claim requirements

All Illinois Medicaid MCOs are required by federal and state regulations to capture specific data regarding services rendered to Medicaid members. It is important that providers adhere to all billing requirements to ensure timely processing and payment of claims, and to avoid unnecessary rejections and/or denials. Illinois MCOs follow CMS billing requirements, except in those instances where Illinois HFS policies differ, in which case HFS guidelines will supersede the CMS requirements. The manual incorporates and indicates those differences where applicable. It is important that all the MCOs have accurate and up-to-date provider information on file to ensure timely claims processing. The minimum basic claims requirements are outlined below.

### IMPACT

To participate in Humana's network, providers must be enrolled via the state's IMPACT website. LTSS providers must, at a minimum, meet all regulatory guidelines. To register on IMPACT, please visit **https://impact.illinois.gov/h**

To verify enrollment, providers and healthcare professionals can log into the HFS IMPACT Provider Enrollment system, a resource tool for Illinois Medicaid-enrolled/registered providers. IMPACT Provider Enrollment is located on the Illinois HFS Medicaid public web portal within the "About IMPACT" area or can be found on the HFS website.

To access the IMPACT Provider Enrollment for specific guidance on proper enrollment, please visit **https://impact.illinois.gov**.

Indications of proper physician or healthcare professional enrollment include:

- Active registration with IMPACT Provider Enrollment on the HFS site
- "Enrollment" or "limited" status indicated in the enrollment type in IMPACT Provider Enrollment
- An NPI for the attending, billing, ordering, prescribing, referring and rendering providers (not applicable to atypical providers) affiliated with the correct Medicaid ID
- A listing in IMPACT Provider Enrollment with all active service and/or billing locations, provider types and provider specialty codes associated with the provider's respective NPI and Medicaid ID
- Eligibility "Start" and "End" dates in IMPACT Provider Enrollment

HFS' IMPACT Provider Enrollment is available to assist physicians and healthcare professionals with enrollment, including change of address, change of ownership and reenrollment issues, via the HFS website.

Guidelines on how physicians and other healthcare professionals should enroll with Illinois MMAI can be found in Chapter 100 General Policy and Procedures: Provider Enrollment Chapter 101, of the **Provider Handbook online**.

All Medicaid providers must be registered through HFS' IMPACT system and have an HFS Medicaid Provider ID number. Claims will not be processed for services rendered prior to the effective date of an IMPACT enrollment. Dates of service and IMPACT effective dates need to match for a claim to process. Providers who provide service prior to their IMPACT effective date cannot be guaranteed payment. A change in ownership or corporate structure which necessitates a new federal tax identification terminates the participation of the enrolled provider in IMPACT. Participation and approval in IMPACT is not transferable and providers must re-enroll. Claims submitted by a new owner using the prior owner's assigned Medicaid ID number are not accepted.

### Provider enrollment in IMPACT

Providers must enroll in IMPACT for the corresponding provider type and category of service for any services they intend to render to an MCO-covered patient. If providers intend to render services under multiple provider types, they need to enroll for separate Medicaid IDs using unique, separate NPI numbers per provider type.

### Categories of Service (COS) and Specialties

Although COS is not directly added to a claim submitted to an MCO via the specialties and sub-specialties registered in the HFS Provider IMPACT system, they are critical to accurate claims payment. If the appropriate specialty or sub-specialties are not registered with HFS, claims are denied. It is suggested that providers confirm they have the correct COS on file with HFS by reviewing the Provider Information Sheet provided by HFS.

## NPIs and TINs

Humana requires each provider to have a National Provider Identifier (NPI) in accordance with s. 1173(b) of the Social Security Act, as enacted by Section 4707(a) of the Balanced Budget Act of 1997. The provider contract requires providers to submit all NPIs to Humana. Humana files the provider's NPIs as part of our provider network file to the state Medicaid agency or our agent. Humana need not obtain an NPI from an entity that does not meet the definition of "healthcare provider" found at 45 CFR 160.103:

- Individuals or organizations that furnish atypical or non-traditional services that are only indirectly related to the provision of healthcare (examples include taxis, home modifications, home delivered meals and homemaker services)
- Individuals or businesses that only bill or receive payment for, but do not furnish, healthcare services or supplies (examples include billing services and re-pricers).

Healthcare providers can apply for NPIs in one of three ways:

- For the most efficient application processing and the fastest receipt of NPIs, use the web-based application process. Simply sign into the National Plan and Provider Enumeration System (NPPES) and apply online (see related links inside CMS).
- Healthcare providers can agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so.
- Healthcare providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, North Dakota, whereby staff at the NPI Enumerator enter the application data into NPPES. The form is available only on request through the NPI Enumerator. Healthcare providers who wish to obtain a copy of this form must contact the NPI Enumerator via any of the following methods:
  - Phone: **800-465-3203** or **TTY 800-692-2326**
  - Email: **customerservice@npienumerator.com**
  - Mail:
  **NPI Enumerator**
  P.O. Box 6059
  Fargo, ND 58108-6059

Providers can share NPI with Humana online through **Availity.com**. By the Code of Federal Regulations, the provider must submit all NPIs to Humana.

Every claim must identify the name and corresponding NPI as well as Tax Identification Number (TIN) for the health facility or health professional that provided the treatment or service. Always ensure that the NPI and TIN used on the claim correspond to the actual provider or site of care. Incorrect NPIs/TINs and/or NPIs and TINs that do not match are two of the most common reasons for claim denials. If you are an atypical provider (i.e., a waiver services provider), submit using your TIN and your HFS Medicaid number.

Below are the most common billing guidelines by provider type. Be sure to consult the applicable section of the IAMHP Comprehensive Billing Manual for specific requirements for your specific HFS provider type.

- **For Professional Claims** – CMS 1500: Provider TINs are required on Field 25 on a professional claim, and the NPI should be inserted in the rendering provider field (Field 24J) and the billing field (Field 33).
- **For Facility/Institutional Claims** – UB-04: Provider TINs are inserted in Field five and the facility NPI should go in Field 56. Individual provider NPIs are required situationally in fields 76 through 79 (this varies, depending on services performed).

## Provider types/category of service/taxonomy codes

All claims must include the 10-character specific provider taxonomy code (e.g., 207Q00000X for Family Practice, 282N00000X for General Acute Care Hospital) to be processed. Information and listings of provider taxonomy codes are available **here**.

The taxonomy code used must match a corresponding Category of Service (COS), Procedure Code (PC), and/or Place of

Service (POS). A crosswalk of taxonomies with COS, PC and POS is available **here**.

## Provider billing for services

Network providers must provide services and supplies and receive payment in accordance with the contractual agreement with the managed care plan.

## Instructions and required clean (complete) claim criteria

Providers should submit a claim to Humana as applicable using the UB-04 or CMS-1500, or a successor version of the billing form, as applicable to providers and the program. Humana provides additional training and education on claims submission in our Provider Orientation and on **our website**.

Atypical providers (i.e., waiver services provider) should submit claims using their TIN and their Illinois Department of Healthcare and Family Services (HFS) Medicaid number. Do not include an NPI. Please reference the Illinois Association of Medicaid Health Plans (IAMHP) Comprehensive Billing Manual.

| HFS provider type | HFS description |
|---|---|
| 090 | Waiver service provider-Elderly (DoA) |
| 092 | Waiver service provider-Disability (DHS/DRS) |
| 093 | Waiver service provider-HIV/AIDS (DHS/DRS) |
| 098 | Waiver service provider-TBI (DHS/DRS) |

The following HFS provider types are considered home- and community-based services (HCBS) providers that can bill to Humana:

To file a claim for Humana-approved services for one of the four HCBS waivers described above, waiver providers are required to register as a waiver provider with IMPACT. Many HCBS providers are considered atypical by HFS' IMPACT system. HFS' IMPACT definition of an atypical provider is: A provider who is delivering services to Medicaid clients that are not considered to be healthcare services. These providers are not required to obtain an NPI. CMS defines atypical providers as providers that do not provide healthcare. This is further defined under Health Insurance Portability and Accountability Act (HIPAA) in Federal regulations at 45 CFR 160.103. Taxi services, home and vehicle modifications, and respite services are examples of atypical providers reimbursed by the Medicaid program. Even if these atypical providers submit HIPAA transactions, they still do not meet the HIPAA definition of healthcare and should not receive an NPI number.

## Provider billing

We accept both electronic and paper claims submissions, but to assist in processing and paying claims efficiently, accurately and in a timely manner, providers are strongly encouraged to submit claims electronically and support the process contractually. For example, electronic claim submissions are immediately processed through pre-import edits to evaluate the validity of the data, HIPAA compliance and member enrollment information.

Healthcare professionals and facilities can use Availity Essentials and electronic data interchange (EDI) services as no-cost solutions for submitting claims electronically.

To register for Availity Essentials or to learn more about Availity claims solutions, visit **Availity.com**.

If submitting a claim to a clearinghouse, use the following payer IDs for Humana:

- Claims: 61101
- Encounters: 61102

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:

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

**Encounters**
Humana Claims Office
P.O. Box 14605
Lexington, KY 40512-4605

## Completing a CMS-1500

The CMS-1500 billing form is used to submit paper claims for professional services. Humana requires providers to use the CMS-1500 billing form when submitting paper claims.

Before submitting a claim, a provider should ascertain that all required attachments are included. All claims that involve other insurance must be accompanied by an explanation of benefits (EOB) or a remittance advice (RA) that clearly states how the claim was paid or the reason for denial.

## Completing the UB-04

The UB-04 form is used when billing for facilities services, including nursing home room and board, supportive living room and board, hospice and intermediate care facilities services.

## Electronic claims submission

Humana can receive electronic claims submission. The acceptable formats include X12 5010 837 professional and institutional formats. Humana also allows for direct data entry (DDE) through **Availity.com**.

When filing an electronic claim, use payer ID 61101 for long-term care claims.

For questions on how to enroll in electronic claims submissions, please call **800-282-4548** or go to **Availity.com**.

Paper claims should be submitted to the address listed on the back of the member's Humana ID card.

## Clean claim submission

Humana can only process clean claim submissions; unclean claims are not processed and are returned to the provider for correction. A clean claim is a submission that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party. It does not include claims submitted by providers under investigation for fraud or abuse or those claims under review for medical necessity.

Humana reimburses providers for the delivery of authorized covered services as described in the mandates and the member's benefit plan. The provider must mail or electronically transfer (submit) the claim to Humana within 180 days of the date of service or discharge from an inpatient setting or the date that the provider was furnished with Humana's correct name and address.

When Humana is the secondary payer, the provider must submit the claim to Humana within 90 calendar days after the final determination of the primary payer and in accordance with the Medicaid Provider General Handbook.

## Claims payment time frames

Humana processes clean claims according to the following time frames:

- For electronic submissions, Humana provides an electronic acknowledgment of the receipt of the claim.
- For paper claims, Humana:
  - Provides claim receipt acknowledgment or provides electronic submitted claim status access to the provider or provider designee
  - Pays or denies 90% of the clean claims within 30 days of receipt
  - Pays or denies 99% of clean paper claims within 90 days of receipt

If applicable, providers paid on a capitation basis are paid according to the time period specified in their provider agreement with Humana. Claims not billed within the required time frame are considered waived.

## Claims resubmission

### For network providers

Humana considers a claim for resubmission only if it is rebilled in its entirety and includes the resubmission code. The provider must include a letter outlining the reason for submission.

### For non-network or non-participating providers

Humana considers a claim resubmission within 365 days from the primary payers' remittance advice or explanation of benefits.

### Claims reconsideration

Providers have 365 days from the date of remittance to resubmit a claim or the original payment is considered full and final for the related claims. Providers must include:

- The nature of the request
- Member's name and date of birth
- Member identification number
- Service or admission date
- Treatment, service or procedure location
- Request-supporting documentation
- A copy of the claim
- A copy of the remittance advice on which the claim was denied or incorrectly paid

Providers must additionally include the following labels on claims when submitting for reconsideration:
**ATTN: Claims Dept. – Reconsideration Claim**
Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

## Medicare and other primary payer sources

Eligible Humana members can access services that are covered by Medicare through fee-for-service Medicare or a Medicare Advantage product. In the MMAI Demonstration, Humana is the payer of last resort for Medicaid-covered services. As applicable, providers must bill any other third-party insurance before submitting a claim to Humana. Humana pays the difference between the primary insurance payment and Humana's allowable amount if the payment from the primary payer is greater than or equal to the amount allowable under the terms of the provider agreement with Humana. Humana has no further obligation for payment. Providers cannot balance bill members.
If the primary insurance carrier denies the claim as a non-covered service, the claim with the denial may be submitted to Humana for a coverage determination.

It is the provider's responsibility to obtain the primary insurance carrier's explanation of benefits (EOB) or the remittance advice for services rendered to members who have insurance in addition to Humana. The primary carrier's EOB or remittance advice should accompany any claims submitted for payment. A detailed explanation of how the claim was paid or denied should be included if not evident from the primary carrier's EOB or the remittance advice. This information is essential for Humana to coordinate benefits.

If a service is a non-covered service or benefits have been exhausted from the primary carrier, the provider is required to get an updated letter from the primary carrier every January and July to submit with each claim. Claims submitted without the EOB for members where third-party insurance is available will be denied in most cases.
To prevent denials due to coding mismatches, claims submitted to the primary carrier on a form that differs from Humana requirements should be clearly marked with "COB Form Type Conversion."

## Overpayment

Humana provides 30 days' written notice to healthcare providers before engaging in overpayment recovery efforts unless the recovery is for duplicate payment. If a provider identifies any overpayments, it is the provider's responsibility under Section 6402(a) of the Patient Protection and Affordable Care Act to report and refund the overpayment within 60 days following its initial identification. In addition, the provider must provide Humana with a written reason for the overpayment (e.g., excess payment under coordination of benefits, etc.).

## Claims status

Providers can check the status of claims by calling Provider Services at **800-787-3311** and selecting the Claims option or via **Availity.com**.

## Prior authorization and referral procedures, including required forms

Service planning must involve the member and/or member representative working cooperatively with the member's care coordinator. Service authorizations must reflect services specified in the plan of care. When service needs are identified, the member must be given information about available providers so that an informed choice of providers can be made.

## Medical and case record standards

Standards must support clean claims, encounter data, program integrity (fraud) requirements, quality enhancement, HIPAA standards and medical necessity. The member case record includes member-specific documents and documentation of all activities, interactions and contacts with the member, their representative, their case manager and any other provider(s) involved in the support and care of the member. The case management member file information is maintained by Humana in compliance with state and federal regulations for record retention. Humana manages this process through an approved policy and procedure that is available on request.

# Additional information of value

## Adopted and applicable provider attestations

Providers must acknowledge and attest that they will maintain compliance and attend and complete abuse, neglect and exploitation training. It is the provider's responsibility to use training materials approved in advance per mandate, maintain necessary training documentation for employees that have contact with Humana members, and make this documentation available on request to Humana and the applicable state agency.

## Home- and community-based services in supportive living facilities

In December 2012, the OIG published Home and Community-based Services in Assisted Living Facilities, OEI-09-08-00360. In the report, the OIG recommended that CMS issue guidance to state Medicaid programs emphasizing the need to comply with federal requirements for covering home- and community-based services (HCBS) under the 1915(c) waiver. CMS also published expectations regarding person-centered plans of care and to provide characteristics of non-home or community-based settings to ensure state compliance with the statutory provisions of Act section 1915(c).

For residential HCBS providers, such as supportive living facilities (SLF), this means:

- A focus on quality of services provided
- An individualized person-centered care plan
- A community integration goal planning process
- The right to receive home- and community-based services in a home-like environment

As a result, Humana may take state-expected intervention or remediation steps. The following are some examples of intervention or remediation steps Humana may implement on discovery that an SLF is not maintaining a home-like environment:

- Humana works with SLF administrators and staff to correct the identified deficiencies within a state- mandated time frame.
- Humana does not refer members to the non-compliant SLF until outstanding deficiencies are resolved.
- Humana terminates network SLFs that consistently fail to exhibit home-like characteristics and do not resolve outstanding issues.
- As a last resort, Humana may counsel members that are not residing in a home-like environment that they cannot continue to receive HCBS waiver services in a noncompliant facility. If the member wants to remain in the SLF, they may face plan disenrollment.
- If Humana terminates a contract with an SLF and the member agrees to move to a different facility, Humana facilitates the transfer of that member to an SLF that meets the home-like environment requirements.

Residential facility providers agree to comply with the home-like environment and community integration language provided by the state. Such language may be included in your provider agreement. All providers also must comply with the applicable Resident Bill of Rights and attest to complying as part of the monitoring process.

# Section III – Behavioral Health

## Program description

### Humana/Carelon partnership

Humana partnered with Carelon Health Options LLC (Carelon) to manage the delivery of behavioral health services for our Medicare-Medicaid Alignment Initiative (MMAI) Demonstration members in Illinois.

The Demonstration is designed to provide members who are dually eligible for both Medicare and Medicaid with high quality, integrated care. Demonstration members are eligible to receive comprehensive assessments, care planning and coordination from Humana. For further details, please refer to the first two sections of this provider manual.

Carelon is a limited liability, managed behavioral health company. Established in 1996, Carelon's mission is to collaborate with our health plan members and network providers to improve the delivery of behavioral health. Carelon provides behavioral health management services to 42 million people through partnerships with more than 50 health plan partners in 50 states. Most often co-located at the physical location of our health plan partners, Carelon's in-sourced approach deploys local-market utilization managers, care managers and provider network professionals into Carelon's business area. This approach facilitates better coordination of care for members with physical, behavioral and social conditions and is designed to support a medical home model. Quantifiable results prove that this approach improves the lives of individuals and their families and helps health plans to better integrate behavioral health with medical health.

### Humana/Carelon behavioral health program

The Humana behavioral health program provides members with access to a full continuum of behavioral health services through Carelon's network of providers. The program's primary goal is to provide medically necessary care in the most clinically appropriate and cost-effective therapeutic settings by ensuring that all health plan members receive timely access to clinically appropriate behavioral health services. Humana and Carelon believe that quality clinical services can achieve improved outcomes for our members.

### Network operations department

In coordination with Humana's Provider Relations Department, Carelon's Network Operations Department is responsible for the procurement and administrative management of Carelon's behavioral health provider network. Carelon's role includes contracting and provider relations functions for all behavioral health contracts. Representatives are easily reached by email at Provider.relations.IL@carelon.com or by phone at **855-481-7044,** Monday through Friday 8 a.m. – 6 p.m., Eastern time. Clinical staff can be reached there 24 hours a day, seven days a week for authorization requests.

### Contracting and maintaining network participation

A Carelon network provider is an individual practitioner, private group practice, licensed outpatient agency or facility credentialed by the Illinois IMPACT system and signed a Provider Services Agreement (PSA) with Humana and Carelon. Network providers agree to provide covered behavioral health and/or substance use services to members, to accept reimbursement according to the rates set forth in each provider's PSA and to adhere to all other terms in the PSA (including this provider manual).

Carelon network providers who maintain approved status remain active network providers unless the PSA is terminated in accordance with the terms and conditions set forth therein. In cases where a network provider is terminated, such providers may notify members of their termination. Carelon also always notify members when their provider has been terminated and work to transition members to another network provider to avoid unnecessary disruption of care.

### About this section

This behavioral health provider policy and procedure section is a legal document incorporated by reference as part of each provider's Carelon provider services agreement or Humana Provider Participation Agreement. The manual serves as an administrative guide outlining Carelon's policies and procedures governing network participation, service provision, claims submission, quality management and improvement requirements. Detailed information also is provided regarding clinical processes, including authorizations, utilization review, care management, reconsiderations and provider appeals.

Information also is provided on billing transactions. Carelon's level-of-care criteria (LOCC) are accessible by calling Carelon at **855-481-7044**.

The manual is posted on both Humana and Carelon's websites and on **eServices**, Carelon's provider portal; only the version on eServices includes Carelon's LOCC. Providers also may request a printed copy of the manual by calling **855-481-7044**.

Manual updates as permitted by the provider services agreement are posted on Humana and Carelon websites and notification may also be sent by postal mail and/or email. Carelon provides network provider notification at least 60 days prior to the effective date of any policy or procedural change impacting network providers, such as payment modification or covered services. Carelon provides 60 days' notice unless the change is mandated sooner by state or federal requirements.

## Carelon transactions and communications

Carelon's website, carelonbehavioralhealth.com, contains answers to frequently asked questions, Carelon's clinical practice guidelines, clinical articles, links to numerous clinical resources and important news for network providers. As described below, eServices and EDI also are accessed through the website.

## Electronic media

To streamline network providers' business interactions with Carelon, we offer three provider tools – eServices, interactive voice recognition (IVR) and electronic data interchange (EDI).

### eServices

Through eServices, Carelon's secure web portal, all provider transactions are supported, which saves time, postage expense, billing fees and reduces paper waste. Access to eServices is free to Humana- contracted Carelon network providers and can be found at carelonbehavioralhealth.com, 24 hours a day, seven days a week.

Some features include:

- Many fields are automatically populated to minimize errors and improve claim approval rates on first submission.
- Claim status is available within two hours of electronic submission.
- All transactions generate a stored printable confirmation and transaction history for future reference.

Given that eServices is a secure site containing member-identifying information, users must register to open an account. There is no limit to the number of users, and the designated account administrator for each provider practice and organization controls which users can access each eServices feature.

**Register for eServices**.

Please have your practice or organization NPI and TIN available. The first user from a provider organization or practice is asked to submit, via fax, a signed copy of the eServices Terms of Use. This first user is designated as the account administrator unless/until another designee is identified by the provider organization. Carelon activates the account administrator's account as soon as the terms of use are received.

Subsequent users are activated by the account administrator on registration. To fully protect member confidentiality and privacy, providers must notify Carelon of a change in account administrator and when any users leave the practice.

**NOTE:** The account administrator should be in a management role, with appropriate authority to manage other users in the practice or organization. The provider may reassign the account administrator at any time by emailing **Provider.relations.IL@carelon.com**.

### Interactive voice recognition

Interactive voice recognition (IVR) is available to providers as an alternative to eServices. It provides accurate, up-to-date information by telephone, and is available for selected transactions by calling **855-481-7044**.

To maintain compliance with HIPAA and all other federal and state confidentiality and privacy requirements, network providers must have their practice or organizational TIN, NPI, as well as member's full name, plan ID and date of birth, when verifying eligibility through eServices and through Carelon's IVR.

### Electronic data interchange

EDI is available for claim submission and eligibility verification directly by providers to Carelon or via an intermediary. For information about testing and EDI setup, download Carelon's 837 and 835 companion guides located on Carelon's provider portal: **837-health-care-claim-companion-guide.pdf** (**carelonbehavioralhealth.com**)

Carelon accepts standard HIPAA 837 professional and institutional healthcare claim transactions and provides 835 remittance advice response transactions.

To set up an EDI connection, view the companion guide located on **Carelon's provider portal**, then contact **e-support.services@beaconhealthoptions.com**. You may submit any technical or business-related questions to the same email address. To submit EDI claims through an intermediary, contact the intermediary for assistance. If using Emdeon, use Carelon's Emdeon Payer ID 43324 and Carelon's health plan code 054.

**Table 3-1 Electronic transactions availability**

| Transaction/capability | eService | Phone | EDI |
|---|---|---|---|
| **Verify member eligibility, benefits and copayment** | Yes | Yes | |
| **Check number of visits available** | Yes | Yes | |
| **Submit authorization requests** | Yes | | |
| **View authorization status** | Yes | Yes | |
| **Update practice information** | Yes | | |
| **Submit claims** | Yes | | Yes (HIPAA 837) |
| **Upload EDI claims to Carelon and view EDI upload history** | Yes | | Yes (HIPAA 837) |
| **View claims status** | Yes | Yes | |
| **Print claims reports and graphs** | Yes | | |
| **Download electronic remittance advice** | Yes | | |
| **EDI acknowledgment and submission reports** | Yes | | Yes (HIPAA 837) |
| **Pend authorization requests for internal approval** | Yes | | |
| **Access Carelon's level-of-care criteria and provider manual** | Yes | | |

## Email

Carelon encourages providers to communicate with Carelon by email addressed to **Provider.relations.IL@carelon.com**. Throughout the year, Carelon sends network providers alerts related to regulatory requirements, protocol changes and helpful reminders regarding claim submission, etc. To receive these notices in the most efficient manner, we strongly encourage you to enter and update email addresses and other key contact information for your practice through eServices.

## Communication of member information

In keeping with HIPAA requirements, providers are reminded that personal health information (PHI) should not be communicated via email, other than through Carelon's eServices. PHI may be communicated by telephone or secure fax.

Unless in certain circumstances, it is a HIPAA violation to include any patient-identifying information or protected health information.

## Access standards

Humana members may access behavioral health services 24 hours a day, seven days a week by calling Humana's Member Services line **855-371-9234**. The main Humana line includes an option for connecting directly to Carelon Health Options member services for emergencies or authorization requests for acute levels of care. For most members, referrals are not required to access behavioral health services. Authorization and referrals are never required for emergency services.

Humana and Carelon adhere to state and NCQA guidelines for access standards for member appointments.

**Table 3-2 Appointment standards and availability**

| Type of care | Appointment availability |
|---|---|
| **Emergency care with crisis stabilization** | Immediate access |
| **Urgent care** | Immediate access |
| **Post discharge from acute hospitalization** | Within seven days of discharge |
| **Other routine referrals or appointments** | Within 30 days |

Access standards for Humana's behavioral health network are established to ensure that members have service access within 30 miles or 30 minutes from their address within urban areas, and 60 miles or 60 minutes of their address within rural areas.

In addition, Humana providers must adhere to the following guidelines to ensure members have adequate access to services:

**Table 3-3 Service availability and after-hours accessibility**

| Service availability | Hours of operation (local time): |
|---|---|
| **On-call** | • 24-hour on-call services for all members in treatment<br>• Ensure that all members in treatment know how to contact the treating or covering provider after hours and during provider vacations |
| **Crisis intervention** | • Services must be available 24 hours a day, seven days a week<br>• Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours<br>• After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency-affiliated staff, crisis team or hospital |
| **Outpatient services** | Outpatient providers should have services available Monday through Friday from 9 a.m. – 5 p.m., at a minimum; evening and/or weekend hours also should be available at least two days per week. |
| **Interpreter services** | Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency. |
| **Cultural competency** | Providers must ensure that members have access to medical interpreters, sign language interpreters, and TTY services to facilitate communication when necessary and ensure that clinicians and agencies are sensitive to the diverse needs of Humana members. |

## Medical homes

All providers are encouraged to consider an affiliation with a medical home. Some providers may serve as a medical home, which is designed to provide fully integrated member care. For further information on the medical home model, please contact Carelon.

## Members with disabilities

Provider locations must be accessible for Humana members with disabilities. As necessary to serve members, provider locations where members receive services must be compliant with the Americans with Disabilities Act (ADA). Providers may be required to attest that their facilities are ADA compliant. Providers are required to meet these standards and notify Carelon if they are temporarily or permanently unable to do so. If a provider fails to provide services within these access standards, notice is sent out within one business day informing the member and provider that the waiting time access standard was not met.

## Provider credentialing and recredentialing

All Illinois providers wishing to participate in the program must be credentialed through IMPACT (**https://hfs.illinois.gov/impact/termsandconditions.html**) for Medicaid. Carelon also conducts a rigorous credentialing process for network providers based on CMS and NCQA guidelines. All providers must be approved for credentialing by Carelon to participate in its behavioral health services network and must comply with recredentialing standards by submitting requested information. Private, individual and group practice clinicians are individually credentialed, while facilities are credentialed as organizations. To request credentialing information and an application(s), please email **Provider.relations.IL@carelon.com**.

## Provider training

Please see Section I of this manual.

## Member billing prohibitions

Health plan members may not be billed for any covered service or any balance after reimbursement by Carelon, except for any applicable copayment. Further, providers may not charge MMAI members for any services not deemed medically necessary on clinical review, or which are administratively denied. It is the provider's responsibility to check benefits prior to beginning treatment for any MMAI member and to follow the procedures set forth in this manual.

## Out-of-network providers

Out-of-network behavioral health benefits are limited to:

- Covered services that are unavailable in the existing Humana or Carelon network
- Emergency services and transition services for members currently in treatment with an out-of-network provider who is in the process of joining the network, or otherwise required by Humana's contract with the state

Out-of-network providers must complete a single case agreement (SCA) with Carelon. Out-of-network providers may provide one evaluation visit for Humana members without an authorization on completion and return of the signed SCA. After the expiration of existing authorizations, the provided services must be authorized by Carelon. Outpatient device authorization requests can be obtained by calling **855-481-7044**. If this process is not followed, Carelon may administratively deny the services and the out-of-network provider must hold the member harmless.

Out-of-network providers who want to join Carelon's network should call **855-481-7044**.

## Provider database

Humana and Carelon maintain a provider-reported database of provider information. This database can be found on Carelon's website carelonbehavioralhealth.com. A hard copy can be requested by calling **855-481-7044**.
Database accuracy is critical to essential functions including:

- Network monitoring to ensure member access to a full continuum of services across the entire geographic service area
- Regulatory reporting requirements
- Member referrals
- Network monitoring to ensure compliance with quality and performance standards including appointment access standards

Provider-reported hours of operation and availability to accept new members are included in Carelon's provider database, along with specialties, licensure, language capabilities, addresses and contact information. This information is visible to members on our website and is the primary information source for us to use when assisting members with referrals. In addition to contractual and regulatory requirements pertaining to appointment access, up-to-date practice information is equally critical to ensuring appropriate referrals to available appointments. The table below lists required notifications. Most of these can be updated via Carelon's eServices portal or by email.

**Required notifications – type of information:**

- General practice information
- Change in address or telephone number of any service
- Addition or departure of any professional staff
- Change in linguistic capability, specialty or program

- Discontinuation of any covered service listed in the Behavioral Health Services Agreement
- Change in licensure or accreditation of provider or any of its professional staff
- Changes in hours of operation
- Cessation of new member acceptance
- Limited hour and setting availability
- Member treatment restrictions
- Temporary or permanent inability to meet Carelon appointment access standards
- Change in designated account administrator for the provider's eServices accounts
- Merger, change in ownership, or change of TIN
- When adding a site, service or program not previously included in the Behavioral Health Services Agreement, please remember to specify the site location and its capabilities

## Adding sites, services and programs

Your contract with Carelon is specific to the sites, rates and services originally specified in your provider service agreement (PSA).

To add a site, service or program not previously included in your PSA, notify Carelon of the new location and any service or program capabilities. Humana and Carelon coordinate to determine whether the site, service or program meets identified geographic, cultural, linguistic and/or specialty network needs.

# Members, benefits and member-related policies

## Covered services

Humana covers behavioral health and substance use services via Carelon that are provided to members located in the state of Illinois. Under the health plan, the following levels of care are covered, provided that such services are:

- Medically necessary
- Delivered by contracted network providers (or as part of a member's transition plan if provider is not in network)

The authorization procedures outlined in this manual should be followed. Please refer to your contract with Carelon for specific information about procedure and revenue codes and rates for these services:

- Outpatient behavioral health and substance use services
- Community-based (Rule 132) mental health services
- Partial hospitalization
- Intensive outpatient services
- Inpatient hospitalization
- Crisis stabilization and observation
- Emergency room (ER) services

Plan members may access behavioral health services by self-referring to a network provider, calling Carelon, or by referral through acute or ER encounters. Members also may access behavioral health services via PCP referral. Some behavioral health and substance use services for Demonstration members may require referral from the member's PCP. Please contact Carelon for more information about referral requirements. Network providers are expected to coordinate care with a member's PCP and other treating providers whenever possible.

## Additional benefit information

- Benefits do not include payment for behavioral health services that are not medically necessary
- Neither Carelon nor Humana is responsible for the costs of investigational drugs or devices, or non-healthcare services such as managing research or the costs of collecting data that is useful for the research project, but not medically necessary for the member's care
- Authorization may be required for all services
- Opioid maintenance is not a covered benefit (with the exception of emergency services)

# Member rights and responsibilities

## Member rights

Humana and Carelon are firmly committed to ensuring that members are active and informed participants in the planning and treatment phases of their behavioral care. We believe that members become empowered through ongoing collaboration with their healthcare providers, and that provider collaboration is crucial to achieving positive healthcare outcomes.

Members must be fully informed of their rights to access treatment and participate in all aspects of treatment planning. Members may request assistance from Carelon or Humana in filing an appeal or a state hearing once their appeal rights have been exhausted. Member rights and responsibilities are generally outlined in Section I of this manual.

## Right to submit Carelon complaints or concerns

Members and their legal guardians have the right to file a complaint or grievance with Humana regarding any of the following:

- The quality of member care delivered by a Carelon network provider
- The Carelon utilization review process
- The Carelon network of services

Member grievances are handled directly by Humana. The procedure for filing a complaint or grievance is described in Grievance and appeals system portion of this manual.

## Right to make recommendations about member rights and responsibilities

Members have the right to make recommendations directly to Carelon regarding Carelon's Member's Rights and Responsibilities statement. Members should direct all recommendations and comments to Carelon's ombudsperson. All recommendations are presented to the appropriate Carelon review committee. The committee then recommends policy changes as needed and appropriate.

## Posting member rights and responsibilities

All network providers must display, in a highly visible and prominent place, a statement of member rights and responsibilities. This statement must be posted and made available in languages consistent with the demographics of the population(s) served. This statement can either be Carelon's statement or a comparable statement consistent with the provider's state license requirements.

## Informing members of their rights and responsibilities

Providers are responsible for informing members of their rights and respecting those rights. In addition to a posted statement of member rights, providers also are required to:

- Distribute and review a written copy of member rights and responsibilities at the initiation of every new treatment episode and include signed documentation of this review in the member's medical record
- Inform members that Carelon does not restrict the ability of network providers to communicate openly with plan members regarding all treatment options available to them – including medication treatment – regardless of benefit coverage limitations
- Inform members that Carelon offers no financial incentives to its network provider community for limiting, denying or not delivering medically necessary treatment to plan members
- Inform members that clinicians working at Carelon receive no financial incentives to limit or deny any medically necessary care

## Non-discrimination policy and regulations

Providers agree to treat plan members without discrimination. Providers may not refuse to accept and treat a health plan member on the basis of:

- Income
- Gender
- Creed
- National origin

- Marital status
- Claims experience
- Pre-existing conditions
- Physical or mental condition
- Sexual orientation
- Color
- English proficiency
- Veteran status
- Duration of coverage
- Health status
- Age
- Religion
- Physical or mental disability
- Ancestry
- Occupation
- Race/ethnicity
- Ultimate payer of services

If a provider cannot provide appropriate member services, they should direct the member to call Carelon for assistance in locating needed services.

Network providers may not close their practice to health plan members unless it is closed to all patients. The exception to this rule is that providers may decline to treat members for whom they do not have the capability or capacity to provide appropriate services. In that case, either the member or the provider should contact Carelon for assistance in locating appropriate services.

State and federal laws prohibit discrimination against any individual who receives federal, state or local public assistance, including medical assistance or unemployment compensation, solely because that person receives assistance.

It is our joint goal to ensure that all members receive medically necessary behavioral healthcare that is accessible, respectful and maintains the dignity of the member.

## Confidentiality of member information

All providers are expected to comply with federal, state and local laws regarding access to member information. With the enactment of HIPAA, members are not required to give consent for the release of information regarding treatment, payment and healthcare operations when enrolling in health insurance, starting treatment or making payment. Healthcare operations involve a number of different activities, including, but not limited to:

- Submission and payment of claims
- Seeking authorization for extended treatment
- QI initiatives, including information regarding member diagnosis, treatment and condition to ensure compliance with contractual obligations;
- Member information reviews in the context of management audits, financial audits or program evaluations
- Chart reviews to monitor the provision of clinical services and ensure that authorization criteria are applied appropriately

## Member consent

At every member intake and treatment admission, providers should explain the purpose and benefits of communication with the member's PCP and other relevant providers. The behavioral health clinician should then ask the member to sign a statement authorizing the clinician to share clinical status information with the PCP and for the PCP to respond with additional member status information.

A sample form is available at **carelonbehavioralhealth.com/providers** (see **Provider Tools web page**), or providers may use their own form; the form must allow the member to limit the scope of shared information.

Members can elect to refuse to consent to the release of any information, treatment, payment and operations, except as specified in the previous section. Whether providing or declining consent, the member's signature is required and should be included in the medical record.

If a member refuses to release information, the provider should clearly document the reason for refusal in the narrative section on the form. In addition, the provider should advise the member that if they refuse authorization for release of information for payment purposes, they will be held personally responsible for payment outside the health plan.

## Confidentiality of HIV-related information

At every treatment intake and admission, providers should explain the purpose and benefits of Carelon's collaboration with the plan to provide comprehensive health services to members with health conditions that are serious, complex and involve both medical and behavioral health factors. Carelon coordinates care with health plan medical and disease management programs and accepts health plan referrals for behavioral healthcare management.

Information regarding HIV infection, treatment protocols and standards, qualifications of HIV/AIDS treatment specialists, and HIV/AIDS services and resources, medications, counseling and testing is available directly from the health plan. Carelon assists behavioral health providers or members interested in obtaining any of this information by referring them to the health plan's care management department.

Carelon limits access to all health-related information – including HIV-related information and medical records — to staff trained in confidentiality and the proper management of patient information. Care management protocols require Carelon to provide any health plan member with assessment and referral to an appropriate treatment source. It is Carelon's policy to follow federal and state information laws and guidelines concerning the confidentiality of HIV-related information.

## Humana health plan member eligibility

Possession of a health plan member identification card does not guarantee member benefit eligibility. Providers are strongly encouraged to frequently check member eligibility.

The following resources are available to assist in eligibility verification:

- Carelon eServices:
- Carelon's provider line: **855-481-7044**

Providers also can use Availity Essentials online to check member eligibility or call Provider Services.

## Provider services: Provider portal

Sign in to Carelon's Provider Portal (carelonbehavioralhealth.com) and select providers from the menu options.

Select "Member Eligibility" on the left, which is the first tab.

Using Carelon's secure provider portal, you can check Humana member eligibility for up to 24 months after the date of service using any of the following:

- Member name and date of birth
- Case number
- Medicaid (MMIS) number
- Humana member ID number

Multiple member ID numbers may be searched in a single request.

Call Carelon Provider TFN at **855-481-7044** from any touch-tone phone and follow the appropriate menu options to verify a member's eligibility.

To maintain HIPAA compliance and all other federal and state confidentiality or privacy requirements, providers must supply their practice or organizational TIN, NPI, the member's full name, plan ID and date of birth when verifying eligibility through eServices and Carelon's IVR. The Carelon Clinical Department also may assist the provider in verifying member enrollment in the Humana health plan when authorizing services.

In accordance with the Privacy Act, Carelon requires the provider be prepared to provide specific identifying information (provider ID number, member's full name and date of birth) during the process to avoid inadvertent disclosure of sensitive health information.

**NOTE:** Member eligibility information on eServices is updated nightly. Eligibility information obtained by phone is accurate when provided. Carelon cannot anticipate, and is not responsible for, retroactive changes or disenrollments reported at a later date.

Providers should frequently check eligibility.

# Quality management and improvement

## Program description

Carelon administers a Quality Management and Improvement (QM and I) Program that strives to continually monitor and improve the effectiveness of behavioral health services delivered to members. Carelon's QM and I Program integrates the principles of continuous quality improvement (CQI) throughout its organization and the provider network.

## Program principles

- Continually evaluate the delivered effectiveness of services provided to health plan members
- Identify areas for targeted improvements
- Develop Quality Improvement (QI) action plans to address improvement needs
- Continually monitor the effectiveness of changes implemented over time

## Program goals and objectives

- Improve member healthcare status
- Enhance continuity and coordination among behavioral healthcare providers and between behavioral healthcare and physical healthcare providers
- Establish effective and cost-efficient disease management programs, including preventive and screening programs, to decrease incidence and prevalence of behavioral health disorders
- Ensure members receive timely and satisfactory service from Carelon and network providers
- Maintain positive and collaborative working relationships with network practitioners and ensure provider satisfaction with Carelon services
- Responsibly contain healthcare costs

## Provider role

Humana and Carelon employ a collaborative model of continuous QM and I, in which provider and member participation is actively sought and encouraged. Humana and Carelon require each provider to develop their own internal QM and I Program to continually assess quality of care, access to care and compliance with medical necessity criteria.

All providers are expected to provide members with disease-specific information and preventive care information that can assist the member with understanding illness and support recovery. Member education should be person-centered, recovery-focused and promote compliance with treatment directives and encourage self-directed care.

Members interested in participation with Carelon's Member Advisory Council should contact the member services department.

## Quality monitoring

Carelon monitors provider activity and utilizes the data generated to assess provider performance related to quality initiatives and specific core performance indicators. Findings related to provider compliance with performance standards and measures are also used in credentialing and recredentialing activities, benchmarking, and identification of individual provider and network-wide improvement initiatives. Humana and Carelon's quality monitoring activities include, but are not limited to:

- Site visits
- Treatment record reviews
- Satisfaction surveys
- Internal monitoring of timeliness and accuracy of claims payment, provider compliance with performance standards including, but not limited to:
  - Timeliness of ambulatory follow-up after behavioral health hospitalization
  - Discharge planning activities
  - Communication with member PCPs, behavioral health provider peers, government and community agencies
  - Tracking of adverse incidents
  - Other quality improvement activities

On a quarterly basis, Carelon's QM and I Department aggregates and analyzes all data collected and presents the results to the QI Committee for review. The QI committee may recommend initiatives at individual provider sites and throughout Carelon's behavioral health network as indicated.

A record of each provider's adverse incidents and any complaints, grievances or appeals pertaining to the provider, is maintained in the provider's credentialing file and may be used by Humana and Carelon in profiling, recredentialing and network (re)procurement activities and decisions.

# Treatment records

## Treatment record reviews

Carelon reviews member charts and utilizes data generated to monitor and measure provider performance in relation to Carelon's treatment record standards and specific quality initiatives established each year. The following elements are evaluated (in addition to any state-specific regulatory requirements) regarding chart review for special services such as Rule 132 services.

- Use of screening tools for diagnostic assessment of substance use, adolescent depression and attention deficit hyperactivity disorder (ADHD)
- Continuity and coordination with primary care and other providers
- Explanation of member rights and responsibilities
- Inclusion of all applicable state-required medical record elements as identified in administrative regulations, service manuals and NCQA
- Allergies and adverse reactions, medications, physical exam and evidence of advance directives

Humana and Carelon may conduct on-site chart reviews at a provider facility or request that specified sections of a member's medical record be sent to Carelon. Any provider questions regarding Carelon's access to the plan member information should be directed to Carelon Privacy by calling **855-481-7044**.

HIPAA regulations permit providers to disclose information without patient authorization to provide oversight of the healthcare system, including quality assurance activities. Carelon chart reviews fall within this area of allowable disclosure.

## Treatment record standards

To ensure that the appropriate clinical information is maintained within the member's treatment record, providers must follow the documentation requirements below. All documentation must be clear and legible. Providers also should adhere to state guidelines for treatment records, such as Rule 132 documentation guidelines, where indicated.

**Table 3-6 Treatment records documentation requirements**

| | |
|---|---|
| **Documentation** | • Is there documentation that the member received a copy of their rights?<br>• Are medication allergies and adverse reactions prominently noted in the record? If the member has no known allergies or adverse reactions, are these noted?<br>• Is past medical history easily identified? If no significant medical history, is this noted?<br>• Is there documentation that the member received a copy of the HIPAA notice of privacy practices? |
| **Continuity and coordination – outpatient to outpatient** | • Is there evidence in the chart that at least one Release of Information, Authorization, or Consent was obtained to speak with at least one other outpatient (OP) mental health or OP substance use treatment provider if required for specially protected information?<br>• Is there evidence that the OP treatment provider contacted another OP BH provider after initial assessment/evaluations for collaboration?<br>• Is there evidence that the OP treatment provider had ongoing contact with other BH provider at other significant points in treatment (e.g., medication initiated, discontinued, or significantly altered; significant changes in diagnosis or clinical status and at termination of treatment)?<br>• Is there evidence that the OP treatment provider contacted, collaborated, received clinical information from or communicated in any way with any state agencies or schools, community outlets, etc.? |

| | |
|---|---|
| **Continuity and coordination - PCP to outpatient** | • Is there evidence in the chart that a Release of Information was obtained to communicate with the PCP if required for specially protected information?<br>• Member refuses due to active symptoms.<br>• Member refuses due to expressed concern over privacy.<br>• Guardian does not want information shared with PCP.<br>• Member will not state a reason. Example: legal issues, member does not want medical records to be released to another party<br>• Is there evidence that the OP treatment provider contacted and collaborated after initial assessment/evaluation?<br>• Is there evidence that the OP treatment provider had ongoing contact with PCP at other significant points in treatment e.g., medication initiated, discontinued, or significantly altered; significant changes in diagnosis or clinical status and at termination of treatment?<br>• Is there evidence of bi-directional communication |
| **Evaluation of treating provider communication (BH:PCP)** | • Is there evidence in the chart that the BH provider communicated with the OP BH Provider within 30 days of initial assessment? (Timeliness: Communication within 30 days of initial assessment) |
| **Clinical practice guidelines (CPG)** | • Adult suicide risk CPG: Was the member asked about thoughts of suicide or self-harm? (18+)<br>• Adult suicide risk CPG: Was a standardized suicide risk screening or assessment tool used? (18+)<br>• Adult suicide risk CPG: If yes to 2., what tool was used?<br>• Adult suicide risk CPG: Where risk was identified, was at least brief safety planning intervention done to develop a plan to recognize suicidal thoughts and manage them safely? (18+)<br>• Adult psychiatric evaluation CPG: Is there documentation of a substance use assessment? (18+)<br>• Adult psychiatric evaluation CPG: Is there documentation of a cultural and/or linguistic assessment? (18+)<br>• Adult psychiatric evaluation CPG: Is there documentation of a medical assessment? (18+)<br>• ADHD CPG: Is there documentation that the member meets the DSM-5 criteria, including documentation of symptoms and impairment in more than one major setting (i.e., social, academic, or occupational)?<br>• ADHD CPG: Is there documentation that when assessing a member's diagnosis, differential diagnoses or alternative causes were ruled out? |
| **Targeted clinical review** | • Is the DSM or ICD diagnosis consistent with presenting problems, history, mental status exam and treatment plan?<br>• Does the treatment plan include objective and measurable goals?<br>• Does the treatment plan include short-term timeframes for goal/objective attainment or problem resolution?<br>• Is utilization appropriate for diagnosis and treatment plan?<br>• Are progress notes goal-oriented and focused on treatment objectives? |
| **Telehealth member safety (applicable to all charts if telehealth modality)** | • Did the BH provider document member's written or oral consent to receive services via telehealth?<br>• Did provider document that session was conducted via video or phone?<br>• Did provider document member's physical location at beginning of session?<br>• If there was a technical difficulty did provider document alternate communication and how session was continued or rescheduled? |

In addition to the MMAI Demonstration member requirements above, providers are required to capture the following information in the member's medical record:

- Date of birth
- A summary of significant surgical procedures
- Description of chief complaint or visit purpose, the objective diagnosis, medical findings and the provider's impression
- Identification of any studies ordered
- Identification of any prescribed and administered therapies
- Disposition, recommendations, member instructions and evidence of follow-up and service outcome
- Immunization history
- Summaries of all emergency services and care and hospital discharges that include appropriate follow-up
- Documentation of member referral services and medical records
- All provider services (family planning services, preventive services, etc.)
- Primary language spoken by the member and any member translation needs
- Identify members needing communication assistance in the delivery of healthcare services

## Advance directives

Carelon practices an integrated approach to advance directives between behavioral health and medical care providers. As per federal law (Patient Self-determination Act, 42 U.S.C.A. § 1396a[w] [West 1996]), providers participating in the Medicare and Medicaid programs are required to furnish patients with information on advance directives. The information is to be given to patients on admission to a facility or when provision of care begins.

Documentation that the member was provided with this information must be noted in the member's treatment record and must specify whether the member executed an advance directive. The member's advance directive decision should be periodically reviewed between the provider, member and/or the member's legal guardian (if applicable). This should be closely coordinated with the care manager around significant changes in the member's condition, diagnosis, and/or level of care.

State law allows for three types of advance directives: (1) healthcare power of attorney; (2) living will; and (3) mental health treatment preference declaration. Providers should ensure that members are informed of these rights.

Forms and documentation regarding advanced directives can be downloaded from the **Illinois Department of Public Health website**.

## Performance standards and measures

To ensure a consistent level-of-care within the provider network, and a consistent framework for evaluating the effectiveness of care, Carelon has developed specific provider performance standards and measures.

Behavioral health providers are expected to adhere to the performance standards for each level of provided member care, which includes, but is not limited to:

- Communication with PCPs and other providers treating shared members
- Availability of routine, urgent and emergent appointments (see Table 3-2)

## Practice guidelines

Humana and Carelon promote delivery of behavioral health treatment based on scientifically proven methods. We researched and adopted evidence-based guidelines for treating the most prevalent behavioral health diagnoses, including guidelines for ADHD and substance use disorders, and posted links to these guidelines on our website.

We strongly encourage providers to use these guidelines and to consider these guidelines whenever they may promote positive outcomes for clients. Carelon monitors provider utilization of guidelines through the use of claim, pharmacy and utilization data.

Carelon welcomes provider comments about the relevance and utility of its guidelines, any improved client outcomes noted as a result of guideline application and about provider experience with any other guidelines. To provide feedback or request paper copies of the Carelon practice guidelines, contact Provider Relations via email at **Provider.Realtions.IL@carelon.com**.

## Outcome measurement

Carelon strongly encourages and supports provider use of outcome measurement tools for all members. Outcome data is used to identify potentially high-risk members who may need intensive behavioral health, medical or social care management interventions. Humana requires that providers document communication attempts (with member consent) to communicate with member primary care provider. Providers are expected to submit quarterly (monthly if applicable) reports to the member's PCP regarding member treatment and progress.

Carelon receives aggregate data by provider, including demographic information and clinical and functional status, without member-specific clinical information.

## Communication between outpatient behavioral health providers, PCPs and other providers

Outpatient behavioral health providers are expected to communicate with the member's PCP and other outpatient behavioral health providers if applicable, as follows:

- Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first
- Updates at least quarterly during the course of treatment
- Notice of initiation and any subsequent modification of psychotropic medications
- Notice of treatment termination within two weeks

Behavioral Health Providers may use Carelon's "Authorization for Coordination of Behavioral Healthcare" form for initial communication and subsequent updates. The form can be found on Carelon's provider portal or providers may use their own form that includes the following information:

- Presenting problem/reason for admission
- Date of admission
- Admitting diagnosis
- Preliminary treatment plan
- Currently prescribed medications
- Proposed discharge plan
- Behavioral health provider contact name and telephone number

Request for PCP response by fax or mail within three business days of the request to include the following health information:

- Status of immunizations
- Date of last visit
- Dates and reasons for any and all hospitalizations
- Ongoing medical illness
- Current medications
- Adverse medication reactions, including sensitivity and allergies
- History of psychopharmacological trials
- Any other medically relevant information.

Outpatient providers' compliance with communication standards is monitored through requests for authorization submitted by the provider and through chart reviews.

## Communication between inpatient/diversionary providers and PCPs, other outpatient providers

With the member's informed consent, acute care facilities should contact the PCP by phone and/or by fax within 24 hours of a member's admission to treatment. Inpatient and diversionary providers also must alert the PCP 24 hours prior to a pending discharge and must fax or mail the following member information to the PCP post-discharge:

- Date of discharge
- Diagnosis
- Medications
- Discharge plan

- Aftercare services for each type, including:
  - Name of provider
  - Date of first appointment
  - Recommended frequency of appointments
  - Treatment plan

Inpatient and diversionary providers should make every effort to provide the same notifications and information to the member's outpatient therapist, if there is one.

Acute care providers' communication requirements are addressed during continued stay and discharge reviews and documented in Carelon's member record.

## State-specific Demonstration model-of-care requirements

Providers must adhere to the following procedures, per state guidelines:

- Facilitate member referral to specialists or specialty care, behavioral health services, health education classes and community resource agencies, when appropriate
- Integrate medical screening with basic primary care services provided to Demonstration members
- Provide screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders
- Deliver evidence-based behavioral health treatment and establish protocols for referral to behavioral health specialty providers
- Ensure member confidentiality of medical and behavioral health and personal information as required by state and federal laws

## Member transfer between behavioral health providers

If a member transfers to another behavioral health provider, the transferring provider must communicate the reason(s) for the transfer along with the information above (as specified for communication from behavioral health provider to PCP), to the receiving provider.

Routine outpatient behavioral health treatment by an out-of-network provider is not an authorized service covered by Carelon. Members may be eligible for transitional care within 30 days after joining the health plan, or to ensure that services are culturally and linguistically sensitive, individualized to meet the specific member needs, timely per Carelon's timeliness standards, and/or geographically accessible.

## Follow-up after behavioral health hospitalization

All inpatient providers are required to coordinate after-care appointments with community based mental health providers prior to member discharge. Carelon's UM and care management staff can assist providers in determining a member's existing treatment engagement with behavioral health providers and assist with referrals to ensure that members released from inpatient levels of care are scheduled for follow-up appointments within seven days of discharge. Providers are responsible for seeing members within that time frame and for reaching out to members who miss their appointments within 24 hours after the appointment is missed.

Carelon's care managers and aftercare coordinators assist by sending member reminders to members, working to remove barriers that may prevent a member from keeping their discharge appointment and coordinating with treating providers.

Network providers are expected to aid in this process as much as possible to ensure that members have the support needed to maintain community placement and prevent unnecessary readmissions.

## Reportable incidents and events

Humana Gold Plus Integrated (Medicare-Medicaid Plan) and Carelon require that all providers report all potential quality of care and critical incidents involving a covered individual on the day of the incident to Carelon by calling 855-371-9234. Potential Quality of Care (PQOC) Concern: Any clinical or system variance warranting further review and investigation to determine the provider's contribution to a quality issue or deviation from the standard of care or service. PQOCs are initial reports of a Serious Reportable Event or Trending Event prior to the conclusion of an investigation.

Humana Gold Plus Integrated (Medicare-Medicaid Plan) requires Carelon network practitioners and providers to report all adverse and critical incidents on the day of the incident to Carelon involving a covered individual. The report should include, but not be limited to, the following. Member safety is paramount. Please call 911, local authorities or emergency medical services if a member's health and safety is at immediate risk.

- Death, member. Does not include natural deaths. Report death that is unusual in nature, particularly if death arose from suspected neglect or abuse.
- Death, other parties. Events that result in significant event for member e.g., death of caregiver while giving member a bath, leaving a member stranded. Does not include family members if no harm to member.
- Physical abuse of member. Non-accidental use of force that results in bodily injury, pain or impairment. Includes but is not limited to being slapped, burned, cut, bruised or improperly physically restrained.
- Verbal/emotional abuse of member
- Sexual abuse of member
- Problematic possession or use of weapon by a member, particularly in staff's presence. Any perceived threat also should be reported.
- Member displays physical aggressive behavior, particularly if violence results in harm or injury to the provider.
- Property damage by customer of $50 or more to provider property.
- Suicide attempt by member and/or suicide ideation/threat by member.
- Suspected alcohol or substance abuse by member
- Seclusion of a member (placing a member in a locked or barricaded area that prevents contact with others).
- Exploitation of member (can include misappropriation of assets or resources of the victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion or in any manner contrary to law).
- Neglect of member (withholding necessities of life including, but not limited to food, clothing, shelter or medical care).
- Sexual harassment by provider, sexual harassment by member, and/or sexual problematic behavior of the member or provider.
- Sexual harassment by member/sexual problematic behavior by member or provider.
- Significant medical event of provider that has the potential to impact a member's care.
- Significant medical event of customer – this includes a recent event or new diagnosis that has the potential to impact the member's health or safety. Also included are unplanned hospitalizations or errors in medication administration by a provider.
- Member arrested, charged with or convicted of a crime – if this could lead to risk or potential risk of a member's health.
- Provider arrested, charged with or convicted of a crime – if this could lead to risk or potential risk of a member's health
- Self-neglect: Individual neglects to attend their basic needs, such as personal hygiene, appropriate clothing, feeding, or tending appropriately to medical conditions.
- Member is missing: member is missing or whereabouts are unknown for provision of services.
- Unauthorized restraint of a member.
- Media involvement/media inquiry – any inquiry or report/article from a media source concerning any aspect of a member's case should be reported via an incident report. Additionally, all media requests are forwarded to the DHS Office of Communications for response.
- Threats made against The Division of Rehabilitation Services (DRS)/Home Services Program (HSP) staff – Threats and/or intimidation manifested in electronic, written, verbal and/or physical acts of violence, or other inappropriate behavior
- Falsification of credentials or medical records or official papers for the expressed interest of personal gain, monetary or otherwise.
- Report against Department of Human Services (DHS)/HSP employee – Deliberate and unacceptable behavior initiated by an employee of DRS against a member or provider in HSP.
- Bribery or attempted bribery of a HSP employee – Money or favor given to an HSP employee in exchange to influence the judgment or conduct of a person in a position of authority.

- Fire/natural disaster – Any event or force of nature that has catastrophic consequences, such as flooding, tornados or fires.
  - In addition to above, Illinois Department on Aging Elder Abuse and Neglect Program (mistreatment of members 60 years of age or older who live in a community), also includes reporting for elderly: physical abuse, sexual abuse, emotional abuse, confinement, passive neglect, willful deprivation, financial exploitation.
  - In addition to above, Illinois Department of Healthcare and Family Services Incident Reporting for Supportive Living Facilities, also includes report for: abuse or suspected abuse, allegations of theft when resident involves local law enforcement, elopement of residents/missing residents, any crime that occurs on facility property, fire alarm activation that results in on-site response by local fire department personnel, physical injury suffered by residents during a mechanical failure or force of nature, loss of electrical power in excess of an hour, evacuation of residents for any reason.

| | |
|---|---|
| **Reporting** | • Carelon's Clinical Department is available 24 hours a day<br>• Providers must call **855-371-9234** to report such incidents, regardless of the hour |
| **Method** | • Providers should direct all such reports to their Carelon clinical manager or Utilization Review (UR) clinician by phone<br>• In addition, Providers are required to complete the PQOC Form.<br>The form can be sent to the Member Safety Team via fax at **855-677-7672** or via email at **corporatepqoc@carelon.com**.<br>Incident and event reports should not be emailed unless the provider is using a secure messaging system |
| **Prepare to provide the following:** | • All relevant information related to the nature of the incident<br>• The parties involved (names and telephone numbers)<br>• The member's current condition |

# Care management

## Care coordination

Humana's integrated management and chronic illness program provides a proactive and comprehensive system of care for enrolled members living with chronic physical diseases, mental illness, substance use disorders and/or developmental and intellectual disabilities. It promotes person-centered, integrated care across the spectrum of medical, behavioral, psycho-social and long-term services and supports. This approach aims at eliminating fragmented and often poorly coordinated healthcare and social services that historically plague effective treatment for these individuals and results in poor health status and ineffectual expenditures.

The description below is designed to provide a broad overview of Humana's care management program. Many members may already receive community-based case management through the community mental health center network in Illinois. Humana and Carelon engage existing case managers whenever possible to ensure continuity of care, avoid unnecessary disruption in services and multiple contacts.

The provider's participation is key and includes the following activities:

- Participation in ICT care conferences via phone, through exchange of written communications and in-person
- Participation in inbound and outbound communications to foster care coordination
- Promote HEDIS and NCQA quality measures
- Provide all medical record documentation and information as requested to support Humana's fulfillment of state and federal regulatory and accreditation obligations, (e.g., HEDIS)

Provider's role and responsibility in care coordination, care transitions, comprehensive medication reviews and preventive screenings:

- Assure that members are informed of specific healthcare needs requiring follow-up and receive self-care training that includes medication adherence and other measures to promote health.
- Ensure the member receives necessary and appropriate specialty, ancillary, emergency and hospital care, and is provided the necessary referrals and communication to specialists, hospitalists, SNFs and other providers needed to assist consultation and treatment recommendation, equipment and/or member services.
- Provide coordination of care for members who are homebound or have significant mobility limitations to ensure access to care through home visits by nurse practitioners or physicians.
- Track and document appointments, clinical treatment plans and member care received from referred to specialists, other healthcare providers or agencies to ensure continuity of care.
- Obtain authorizations and notify Humana for any out-of-network services when an in-network provider of the specialty in question is not available in the geographical area.
- Work with Humana's care coordination team to arrange for a member to receive a second opinion from a qualified in-network healthcare professional or arrange for the member to obtain one outside the network, if a qualified in-network provider is unavailable.
- Initiate or assist with the discharge or transfer of members from an inpatient facility to the most medically appropriate level-of-care facility or back to the member's home or permanent place of domicile. Consider the availability of in-network facilities and obtain appropriate authorizations if using out-of-network facilities.
- Support, participate in, and communicate with the ICT in person and/or in writing, in development and implementation of an individualized plan of care to facilitate effective care coordination.
- Provide timely access to medical records or information for quality management and other purposes, including audits, reviews of complaints or appeals, HEDIS, and other studies, and promptly respond to recommendations for improvement by developing and enacting a corrective/improvement plan, as appropriate.
- Follow the preventive care guidelines set by the U.S. Preventive Services Task Force and provide and document the preventive care services required by the NCQA for HEDIS quality assurance reporting requirements.

## Provider creation and participation in individualized care plans

The individualized care plan is based on:

- Initial and ongoing HRA and comprehensive assessment results
- Claims history
- Plans developed for each member by the ICT

- Member-driven goals, objectives and interventions
- Specific services and benefits
- Measurable outcomes

Provider participation as an integral member of the ICT. The ICT is a team of caregivers from different professional disciplines who work together to deliver care services that optimize quality of life and support the member and/or family.

The ICT may include and support the following:

- The member and/or their authorized caregiver
- The member's physicians and/or nurses
- Humana's care managers and coordinators
- Social workers and community social-service providers
- Humana's and/or the member's behavioral health professionals
- Humana's community health educators and resource-directory specialists
- The physician's goals via the Humana Cares team of nurses, social workers, pharmacy specialists and behavioral health specialists
- Member education and enhancement of direct patient-physician communication
- Self-care management and informed healthcare decision-making
- Care coordination and care transitions
- Access and connections to additional community resources and Medicaid services
- Appropriate end-of-life planning
- Initiation or assistance with the discharge or transfer of members from an inpatient facility to the most medically appropriate level-of-care facility or back to the member's home or permanent place of domicile. Consider the availability of in-network facilities and obtain appropriate authorizations if using out-of-network facilities.
- Supporting, participating in, and communicating with the ICT, in person and/or in writing, in developing and implementing an individualized plan of care to facilitate effective care coordination
- Providing timely access to medical records or information for quality management and other purposes, including audits, reviews of complaints or appeals, HEDIS and other studies, and promptly respond to recommendations for improvement by developing and enacting a corrective/improvement plan, as appropriate.
- Following preventive care guidelines set by the U.S. Preventive Services Task Force and providing and documenting the preventive care services required by the NCQA for HEDIS Quality Assurance reporting requirements.

Working with Demonstration members with a mental health diagnosis:

- Facilitate referral of the member to specialists or specialty care, behavioral health services, health education classes and community resource agencies, when appropriate.
- Integrate medical screening along with basic primary care services provided to Demonstration members; provide screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.
- Deliver evidence-based behavioral health treatment and establish protocols for referral to behavioral health specialty providers.
- Ensure confidentiality of members' medical and behavioral health and personal information as required by state and federal laws.

Understanding chronic conditions prevalent within the Demonstration population:

- Multiple chronic conditions increase the risks for poor outcomes such as mortality and functional limitations as well as the risk of high-cost services such as hospitalizations and emergency room visits. Evidence indicates that preventive care and frequent/consistent care of chronic conditions lowers the advent of major conditions and decreases use of emergency room visits and readmissions.
- Humana's Clinical Practice Guidelines, available on Humana's website to both affiliated and non-affiliated providers, adopt relevant, evidence-based medical and behavioral health guidelines (preventive and certain non-preventive acute and chronic conditions) from recognized sources such as professional medical associations, voluntary health organizations and NIH centers and institutes.

- Humana provides chronic disease management services and support to promote self-management for individuals with chronic conditions.

## State transition of care requirements

To meet the transition of care requirements of the state, the following procedures should be used by Humana and Carelon providers:

- In those instances when the member's care is to be transitioned to a new provider or providers either during the transition period and once the transition period is over, the care coordinator follows the following procedures to ensure the member receives ongoing care:
  - Identify appropriate providers in the member's geographic area that meet cultural and linguistic needs
  - Review the list of recommended behavioral health providers with the member
  - Encourage the member to select a recommended behavioral health provider; if unable, the care coordinator can select
  - Assist member in scheduling an appointment with the identified provider
  - Obtain member permission to share relevant assessment findings with selected behavioral health provider
  - Obtain member permission for the exchange of relevant health information between new behavioral health provider, PCP and other providers

# Utilization management

Utilization management (UM) is a set of formal techniques designed to monitor use of or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, care management, discharge planning and retrospective review.

Carelon's UM program is administered by licensed, experienced clinicians who are specifically trained in utilization management techniques and in Carelon's standards and protocols. All Carelon employees with responsibility for making UM decisions have been made aware that:

- All mental health UM decisions are based on Carelon's level-of-care/medical necessity criteria; substance use level-of-care decisions are made based on American Society of Addiction Medicine criteria
- Financial incentives based on an individual UM clinician's number of adverse determinations or denials of payment are prohibited
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization

**Note:** The information in this section, including definitions, procedures, and determination and notification time frames may vary for different lines of business based on differing regulatory requirements. Such differences are indicated where applicable.

## Community-based service providers

All community-based service providers (Rule 132 providers) are expected to follow all regulations and guidelines set forth in Rule 59 ILAC 132.

## Level-of-care criteria

Carelon's level-of-care criteria (LOCC) are the basis for all medical necessity determinations; accessible through eServices, they include Carelon's Illinois-specific LOCC for each level of care. The following are Carelon's medical necessity criteria:

- CMS criteria
  - The Medicare Coverage Database (MCD) contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
- Change Healthcare's InterQual® Behavioral Health Criteria
- American Society of Addiction Medicine (ASAM) Criteria
  - The American Society of Addiction Medicine (ASAM) Criteria focuses on substance use treatment
  - Unless custom criteria exist or for Substance Use Lab Testing (which is found in in InterQual® Behavioral Health Criteria), ASAM criteria is the criteria for substance use treatment services
- Carelon's National Medical Necessity Criteria

Carelon's LOCC are applied to determine appropriate care for all members. In general, members are certified only if they meet the specific medical necessity criteria for a particular level of care. However, the individual's specific needs and the characteristics of the local service delivery system may be taken into consideration.

## Utilization management terms and definitions

The definitions below describe utilization review that includes the various authorization request and UM determination types used to guide Carelon reviews and decision-making. All determinations are based upon review of the available information provided to Carelon at the time.

| Table 3-8 UM terms and definitions | |
|---|---|
| **Adverse benefit determination**<br>**Adverse action** | • (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner, as defined by the state; (v) the failure of the MCO to act within the required timeframes for the standard resolution of grievances and appeals; (vi) for a resident of a rural area with only one Demonstration Plan, the denial of an member's request to obtain services outside of the network; or (vii) the denial of an member's request to dispute a financial liability. |
| **Adverse action** | The following actions or inactions by Carelon or the provider organization:<br>• Carelon's denial, in whole or in part, of payment for a service failure to provide covered services in a timely manner in accordance with the waiting time standards<br>• Carelon's denial or limited authorization of a requested service, including the determination that a requested service is not a covered service<br>• Carelon's reduction, suspension or termination of a previous authorization for a service<br>• Carelon's denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute adverse actions, including, but not limited to, denials based on the following:<br>- Failure to follow prior authorization procedures<br>- Failure to follow referral rules<br>- Failure to file a timely claim<br>• Carelon's failure to act within the time frames for making authorization decisions<br>• Carelon's failure to act within the time frames for making appeal decisions |
| **Non-urgent concurrent review and decision** | Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments. A non-urgent concurrent decision may authorize or modify requested treatment over a period of time or a number of days or treatments, or deny requested treatment, in a non- acute treatment setting. |
| **Non-urgent preservice review and decision** | Any case or service that must be approved before the member obtains care or services. A non-urgent preservice decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment, in non-acute treatment setting. |
| **Post-service review and decision (retrospective decision)** | Any review for care or services already received. A post service decision would authorize, modify or deny payment for a completed course of treatment where a preservice decision was not rendered, based on the information that would have been available at the time of a pre-service review. |
| **Urgent care request and decision** | Any request for care or treatment for which application of the normal time period for a non-urgent care decision could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment. Denial of care or treatment would subject the member to severe pain that could not be adequately managed without care, in the opinion of a practitioner with knowledge of the member's medical condition. |
| **Urgent concurrent review decision** | Any review for a requested extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments in an acute treatment setting, when a member's condition meets the above definition of urgent care. |

| | |
|---|---|
| **Urgent preservice decision** | Formerly known as a precertification decision, any case or service that must be approved before a member obtains care or services in an inpatient setting, for a member whose condition meets the definition of urgent care above. An urgent preservice decision may authorize or modify requested treatment over a period of time or number of days or treatments or deny requested treatment in an acute treatment setting. |

## Authorization procedures and requirements

This section describes the processes for obtaining authorization for inpatient, community-based diversionary and outpatient levels of care, and for Carelon's medical necessity determinations and notifications. In all cases, the treating provider (whether admitting facility or outpatient practitioner) is responsible for following the presented procedures and requirements to ensure payment for properly submitted claims.

Administrative denials may be rendered when applicable authorization procedures, including time frames, are not followed. Members cannot be billed for services that are administratively denied due to a provider not following the requirements listed in this manual.

## Member eligibility verification

The first step in seeking authorization is to determine the member's eligibility. Since member eligibility changes occur frequently, providers are advised to verify a health plan member's eligibility on admission to, or initiation of, treatment, and on each subsequent day or date of service, to facilitate reimbursement for services. Member eligibility can change, and possession of a health plan member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check Carelon's eServices or call Carelon Provider Service at **855-481-7044**.

# Emergency services

## Definition

Emergency services are those physician and outpatient hospital services, procedures and treatments, including psychiatric stabilization and medical detoxification from drugs or alcohol, needed to evaluate or stabilize an emergency medical condition. The definition of an emergency is listed in your PSA.

Emergency care will not be denied; however, subsequent days do require pre-service authorization. The facility must notify Carelon as soon as possible and no later than 24 hours after an emergency admission and/or learning that the member is covered by the health plan. If a provider fails to notify Carelon of an admission, Carelon may administratively deny any days that are not prior-authorized.

If a member has a behavioral health emergency:

- If a member has a life-threatening emergency or an emergency that poses a threat to the lives of others or property, they should call 911 or go directly to the nearest emergency room. They do not need to get approval or a referral from their PCP first.
- If a member has a behavioral health crisis, they can get help by calling the crisis hotline at **855-371- 9234 (TTY: 711)**. Qualified mental health professionals are available 24 hours per day, seven days per week to answer their questions, assess their mental health, and provide and coordinate services as needed.
- As soon as possible, the member should tell Carelon about their emergency. Carelon follows up on their emergency care. Members should call Humana Provider Services at **800-787-3311 (TTY: 711)**, Monday through Friday, 7 a.m. – 7 p.m., Central time.

## Emergency screening and evaluation

Plan members must be screened for an emergency medical condition by a qualified behavioral health professional from the hospital emergency room, mobile crisis team or by an emergency service program. This process allows members access to emergency services as quickly as possible and at the closest facility or by the closest crisis team.

After the evaluation is completed, the facility or program clinician should call Carelon to complete a clinical review, if admission to a level of care that requires precertification is needed. The facility/program clinician is responsible for locating a bed but may request Carelon's assistance. Carelon may contact an out-of-network facility in cases where there is no timely or appropriate placement available within the network. In cases where there is no in-network or out-of-network psychiatric facility available, Carelon authorizes boarding the member in a medical unit until an appropriate placement becomes available.

## Carelon clinician availability

All Carelon clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures. Carelon clinicians are available 24 hours a day, seven days a week to receive crisis calls from providers for authorization of inpatient admission.

## Disagreement between physician adviser and attending physician

For acute services, in the event that Carelon's physician adviser and the emergency service physician do not agree on the service that the member requires, the emergency service physician's judgment shall prevail and treatment shall be considered appropriate for an emergency medical condition, if such treatment is consistent with generally accepted principles of professional medical practice and is a covered benefit under the member's program of medical assistance or medical benefits. All Carelon clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures.

## Authorization requirements

For a complete listing of covered services and authorization requirements, please refer to Section I.

## Outpatient treatment

Many Humana members you treat have individualized care plans and a care manager. It is critical that you communicate with the care manager about the services you plan to provide so that they can be included in the member's care plan and be authorized appropriately.

The care manager assists you in optimizing the benefits for each member you treat. While traditional outpatient services do not require prior authorization, our care managers work with treating providers to ensure that members get the care they need. Carelon conducts outlier management of outpatient care in addition to care coordination.

Please refer to your contract for specific information about procedure and revenue codes that should be used for billing. Services that indicate "eRegister" will be authorized via Carelon's eServices portal. Providers are asked a series of clinical questions to support medical necessity for the service requested. If sufficient information is provided to support the request, the service is authorized.

If additional information is needed, the provider is prompted to contact Carelon via phone to continue the request for authorization.

While Carelon prefers providers to make requests via eServices, we work with providers who do have technical or staffing barriers to requesting authorizations in this way.

Authorization decisions are posted on eServices within the decision time frames outlined in Table 3-9. Providers receive an email message alerting them that a determination has been made. Carelon also faxes authorization letters to providers on request; however, we strongly encourage providers to use eServices instead of receiving paper notices.

Providers can opt out of receiving paper notices on Carelon's eServices portal. All notices clearly specify the number of units (sessions) approved, the time frame within which the authorization can be used, and explanation of any modifications or denials. All denials can be appealed according to the policies outlined in this manual.

All forms can be found at **carelonbehavioralhealth.com** under "Provider."

## Inpatient services

All inpatient services (including inpatient electroconvulsive treatment [ECT}) require telephonic prior authorization within 24 hours of admission. Providers should call Carelon at **855-481-7044** for all inpatient admissions, including detoxification provided on a psychiatric floor or in freestanding psychiatric facilities and authorization for detoxification. Continued-stay reviews require updated clinical information that demonstrates active treatment. Additional information about what is required during preservice and concurrent stay reviews is listed below.

# UM review requirements – inpatient and diversionary

The facility clinician making the request needs the following information for a preservice review:

- Member's health plan identification number
- Member's name, gender, date of birth, and city or town of residence
- Admitting facility name and date of admission
- DSM-IV diagnosis: All five axes are appropriate; Axis I and Axis V are required. A provisional diagnosis is acceptable.
- Description of precipitating event and current symptoms requiring inpatient psychiatric care
- Medication history
- Substance use history
- Prior hospitalizations and psychiatric treatment
- Member's and family's general medical and social history
- Recommended treatment plan relating to admitting symptoms and the member's anticipated response to treatment

To conduct a continued-stay review, call a Carelon UR clinician with the following required information:

- Member's current diagnosis and treatment plan, including physician's orders, special procedures and medications
- Description of the member's response to treatment since the last concurrent review
- Member's current mental status, discharge plan, and discharge criteria, including actions taken to implement the discharge plan
- Report of any medical care beyond routine is required for coordination of benefits with health plan (routine medical care is included in the per diem rate)

Post-service reviews may be conducted for inpatient, diversionary or outpatient services rendered when necessary. To initiate a post-service review, call Carelon. If the treatment rendered meets criteria for a post-service review, the UR clinician requests clinical information from the provider including documentation of presenting symptoms and treatment plan via the member's medical record. Carelon requires only those section(s) of the medical record needed to evaluate medical necessity and appropriateness of the admission, extension of stay, and the frequency or duration of service. A Carelon physician or psychologist completes a clinical review of all available information to render a decision.

Authorization determinations are based on the clinical information available at the time the member care was provided. Members must be notified of all preservice and concurrent denial decisions. The service is continued without liability to the member until the member has been notified of the adverse determination.

The denial notification letter sent to the member or member's guardian, practitioner and/or provider includes the specific reason for the denial decision, the member's presenting condition, diagnosis and treatment interventions, the reason(s) why such information does not meet the medical necessity criteria, reference to the applicable benefit provision, guideline, protocol or criterion on which the denial decision was based, and specific alternative treatment option(s) offered by Carelon, if any. Based on state and/or federal statutes, an explanation of the member's appeal rights and the appeals process is enclosed with all denial letters. Notice of inpatient authorization is mailed to the admitting facility. Providers can request additional copies of adverse determination letters by contacting Carelon.

## Return of inadequate or incomplete treatment requests

All requests for authorization must be original and specific to the dates of service requested and tailored to the member's individual needs. Carelon reserves the right to reject or return authorization requests that are incomplete, lacking in specificity or incorrectly filled out. Carelon provides an explanation of action(s) which must be taken by the provider to resubmit the request.

## Notice of inpatient/diversionary approval or denial

Verbal notification of approval is provided at the time of preservice or continuing stay review. Notice of admission or continued stay approval is mailed to the member or member's guardian and the requesting facility within the time frames specified later in this chapter.

If the clinical information available does not support the requested level of care, the UR clinician discusses alternative levels of care that match the member's presenting clinical symptomatology, with the requestor. If an alternative setting is agreed to by the requestor, the revised request is approved. If agreement cannot be reached between the Carelon UR clinician and the requestor, the UR clinician consults with a Carelon psychiatrist or psychologist (for outpatient services

only). All denial decisions are made by a Carelon physician or psychologist (for outpatient services only). The UR clinician and/or Carelon physician adviser offers the treating provider the opportunity to seek reconsideration if the request for authorization is denied.

All member notifications include instructions on how to access interpreter services, how to proceed if the notice requires translation or a copy in an alternative format, and toll-free telephone numbers for TDD/TTY capability, in established prevalent languages (Babel Card).

## Termination of outpatient care

Carelon requires that all outpatient providers set specific termination goals and discharge criteria for members.

Providers are encouraged to use the LOCC (accessible through eServices) to determine if the service meets medical necessity for continuing outpatient care.

## Decision and notification time frames

Carelon is required by the state and federal governments to render utilization review decisions in a timely manner to accommodate the clinical urgency of a situation. Carelon adopted the strictest time frame for all UM decisions to comply with the various requirements.

The time frames below present Carelon's internal time frames for rendering a UM determination and notifying members of such determination. All time frames begin at the time of Carelon's receipt of the request. Please note the maximum time frames may vary from those on the table below on a case-by-case basis in accordance with state and federal governments or requirements established for each line of business.

When the specified time frames for standard and expedited prior authorization requests expire before Carelon makes a decision, an adverse action notice goes out to the member on the date the time frame expires.

## Request for reconsideration of adverse determination

If a health plan member or member's provider disagrees with a utilization review decision issued by Carelon, the member, their authorized representative, or the provider may request reconsideration. Please call Carelon promptly after receiving notice of the denial for which reconsideration is requested.

When reconsideration is requested, a PA reviews the case based on the information available and makes a determination within one business day. If members, member representatives or providers are not satisfied with the outcome of reconsideration, they may file an appeal.

**Table 3-9 Decision and notification time frames**

| | Type of decision | Decision time frame | Verbal notification | Written notification |
|---|---|---|---|---|
| **Preservice review** | | | | |
| **Initial authorization for other urgent behavioral health services** | Urgent | Within 72 hours | Within 72 hours | Within 72 hours |
| **Initial authorization for non-urgent behavioral health services** | Standard | Within 14 calendar days | Within 14 calendar days | Within 14 calendar days |
| **Concurrent review** | | | | |
| **Continued authorization for inpatient and other urgent behavioral health services** | Urgent/expedited | Within 24 hours | Within 24 hours | Within three calendar days |
| **Continued authorization for non-urgent behavioral health services** | Non-urgent/ standard | Within 14 calendar days | Within 14 c alendar days | Within 14 calendar days |

| | | | | |
|---|---|---|---|---|
| **Post service** | | | | |
| **Authorization for behavioral health services already rendered** | Non-urgent/ standard | Within 30 calendar days | Within 30 calendar days | Within 30 calendar days |

# Provider appeals

## Provider appeals and grievance procedures

You have the right to file a medical necessity appeal with Humana. Please refer to Humana's Grievance and Appeals Procedures for further information.

You have the right to file with Carelon:

- Contractual appeals
- Administrative appeals (i.e., claims appeals)
- Provider grievances

## How to submit a provider appeal

### Claim appeals

Provider disputes may be submitted via telephone by calling **855-481-7044** Monday through Friday, 7 a.m. – 5 p.m., Central time.

### Email

Provider claims disputes submitted in writing must be emailed to **WoburnClaimAppeals@carelon.com**.

### Fax

Provider disputes can be submitted via fax to **305-722-3013**.

### Provider Portal:

Provider Portal (**carelonbehavioralhealth.com**)

Select "tools" and enter the health plan name, and then select "Claims."

### Writing

Use the "Claim Inquiry Form" on our website. Please include:

- The member's name and Humana member ID number
- The provider's name and Carelon Provider ID number
- The code(s) and reason why the determination should be reconsidered
- If you are submitting a timely filing appeal, you must send proof of original receipt of the appeal by fax or EDI for reconsideration
- If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification for reversing the determination

### Mail:

**Carelon Health Options**
P.O. Box 1856
Appeals Department
Hicksville, NY 11802-1856

## Member grievance, appeals and fair hearing requests

Members have the right to file a grievance or appeal. They also have the right to request a state hearing once they exhaust their appeal rights. Please refer to Humana's member grievance and appeals procedures for further information.

Carelon strongly encourages providers to rely on electronic submission, either through EDI or eServices, to achieve the highest success rate of first-submission claims.

# General claim policies

Carelon requires that providers adhere to the following policies with regard to claims.

## Clean claims

A clean claim, as discussed in this provider manual, the provider services agreement and in other Carelon informational materials, is defined as a claim that has no defect and is complete, including required substantiating documentation of particular circumstance(s) warranting special treatment without which timely payments on the claim would not be possible.

## Electronic billing requirements

The required edits, minimum submission standards, signature certification form, authorizing agreement and certification form, and data specifications as outlined in this manual must be fulfilled and maintained by all providers and billing agencies submitting electronic media claims to Carelon.

## Provider responsibility

The individual provider is ultimately responsible for accuracy and valid reporting of all claims submitted for payment. A provider using the services of a billing agency must ensure through legal contract (a copy of which must be made available to Carelon on request) the responsibility of a billing service to report claim information as directed by the provider in compliance with all policies stated by Carelon.

## Limited information use

All information supplied by Carelon or collected internally within the computing and accounting systems of a provider or billing agency (e.g., member files or statistical data) can be used only by the provider in the accurate accounting of claims containing or referencing that information. Any redistributed or dissemination of that information by the provider for any purpose other than the accurate accounting of behavioral health claims is considered an illegal use of confidential information.

## Member billing prohibition

Providers are not permitted to bill health plan members under any circumstances for covered services rendered, excluding copayments when appropriate.

## Carelon right to reject claims

At any time, Carelon can return, reject or disallow any claim, group of claims or submission received pending correction or explanation.

## Carelon recoupments and adjustments

Carelon reserves the right to recoup money at any time from providers due to errors in billing and/or payment.

In that event, Carelon applies all recoupments and adjustments to future claims processed and reports such recoupments and adjustments on the EOB with Carelon's Record Identification Number (REC.ID) and the provider's patient account number.

## Claim turnaround time

Clean claims are adjudicated within 30 days from the date on which Carelon receives the claim.

Claims for inpatient services:

- The date range on an inpatient claim for an entire admission (i.e., not an interim bill) must include the admission date through the discharge date. The discharge date is not a covered day of service but must be included as the "to" date. Refer to authorization notification for correct date ranges.
- Carelon accepts claims for interim billing that include the last day to be paid as well as the correct bill type and discharge status code. On bill type X13, where X represents the "type of facility" variable, the last date of service included on the claim will be paid and is not considered the discharge day.
- Providers must obtain authorization from Carelon for all ancillary medical services provided while a health plan member is hospitalized for a behavioral health condition. Such authorized medical services are billed directly to the health plan.

- Carelon's contracted reimbursement for inpatient procedures reflect all-inclusive per diem rates.

## Coding

When submitting claims through eServices, users will be prompted to include appropriate codes to complete the submission, and drop-down menus appear for most required codes. See EDI Transactions – **837 Companion Guide** for placement of codes on the 837 file. Please note the following requirements with regard to coding:

- Providers are required to submit HIPAA-compliant coding on all claim submissions; this includes the appropriate HIPAA-compliant revenue, DSM, CPT, HCPCS and ICD codes. Providers should refer **to the Carelon provider portal** for a complete listing of contracted, reimbursable procedure codes.
- Carelon accepts only the appropriate ICD diagnosis codes approved by CMS and HIPAA. All diagnosis codes submitted on a claim form must be a complete diagnosis code with appropriate check digits.
- Claims for inpatient and institutional services must include the appropriate discharge status code and be billed in accordance with the National Uniform Billing Committee (NUBC) standards.
- All UB-04 claims must include the three-digit bill type code and be billed in accordance with the NUBC standards.

## Modifiers

Modifiers can reflect the discipline and licensure status of the treating practitioner or are used to make up specific code sets that are applied to identify services for correct payment. The table below lists some HIPAA-compliant modifiers accepted by Carelon. Please see your Behavioral Health Services Agreement for modifiers that are included in your contract.

**Table 3-10 Modifiers**

| HIPAA modifier | Modifier description | HIPAA modifier | Modifier description |
|---|---|---|---|
| AH | Clinical psychologist | HR | Family/couple with client present |
| AJ | Clinical social worker | HS | Family/couple without client present |
| HB | Adult program, non-geriatric | HU | Funded by child welfare agency |
| HC | Adult program, geriatric | HW | Funded by state behavioral health agency |
| HD | Pregnant/parenting women's program | HX | Funded by county/local agency |
| HF | Substance use program | SE | State and/or federally funded programs/ services |
| HG | Opioid addiction treatment program | TD | Registered nurse |
| HH | Integrated behavioral health/ substance use program | TF | Intermediate level of care |
| HI | Integrated behavioral health/ developmental disabilities program | TG | Complex/high level of care |
| HK | Specialized behavioral health programs for high-risk populations | TJ | Program group, child and/or adolescent |
| HM | Less than bachelor's degree level | UK | Service provided on behalf of the client to someone other than the client-collateral relationship |
| HO | Master's degree level | U4 | Social work intern |
| HP | Doctoral level | U6 | Psychiatrist (This modifier required when billing for 90862 provided by a psychiatrist.) |
| HQ | Group setting | UD | Substance use service |
| HN | Bachelor's degree level | U3 | Psychology intern |

## Time limits for filing claims

Carelon Health Strategies must receive claims for covered services within the following designated filing limits:

- Within 60 days of the dates of service on outpatient claims
- Within 60 days of the date of discharge on inpatient claims

Providers are encouraged to submit claims as soon as possible for prompt adjudication.

Claims submitted after the 60-day filing limit are denied unless submitted as a waiver or reconsideration request, as described in this manual.

## Coordination of benefits (COB)

In accordance with The National Association of Insurance Commissioners (NAIC) regulations, Carelon Health Options coordinates benefits for behavioral health and substance use claims when it is determined that a person is covered by more than one health plan, including Medicare:

- When it is determined that Carelon Health Options is the secondary payer, claims must be submitted with a copy of the primary insurance's explanation of benefits report and received by Carelon within 60 days of the date on the EOB.

Carelon Health Options reserves right of recovery for all claims in which a primary payment was made prior to receiving EOB information that deems Carelon the secondary payer. Carelon applies all recoupments and adjustments to future claims processed and reports such recoupments and adjustments on the EOB.

## Summary

To help providers that may be experiencing claims payment issues, Carelon runs quarterly reports identifying those providers that may benefit from outreach and education. Providers with low approval rates are contacted and offered support and documentation material to assist in reconciliation of billing issues that have an adverse financial impact and ensure proper billing practices within Carelon's documented guidelines.

Carelon's goal in this outreach program is to assist providers in as many ways as possible to receive payment in full, based on contracted rates, for all services delivered to members.

## How the program works

- A quarterly approval report is generated that lists the percentage of claims paid in relation to the volume of claims submitted.
- All providers below 75% approval rate have an additional report generated listing their most common denials and the percentage of claims they reflect.
- An outreach letter is sent to the provider's billing director as well as a report indicating the top denial reasons. A contact name is given for any questions or to request further assistance or training.

## Claim inquiries and resources

Additional information is available through the following resources:

- Online at **carelonbehavioralhealth.com/providers**
- Carelon's claims page
- eServices User Manual
- EDI Transactions – 837 Companion Guide
- EDI Transactions – 835 Companion Guide

## Email contacts

- **Provider.relations.IL@carelon.com**
- **e-support.services@beaconhealthoptions.com**

## Telephone contact info

Interactive Voice Recognition (IVR): **855-481-7044**

Providers should have your practice or organization's TIN, the member's identification number and date of birth, and the date of service.

Claims Hotline: **855-481-7044**

Hours of operation are Monday through Friday, 7 a.m. – 5 p.m., Central time.

An after-hours team is available until midnight to handle crisis calls.

## Main Carelon telephone numbers

- Provider Services – **855-481-7044**
- Member Services – **855-371-9234**
- EDI – **888-247-9311**
- TTY –**711**
- Fax – **855-371-9232**

## Electronic media options

Providers are expected to complete claim transactions electronically through one of the following applicable methods:

### Electronic Data Interchange

EDI supports electronic submission of claim batches in HIPAA-compliant 837P format for professional services and 837I format for institutional services. Providers may submit claims using EDI/837 format directly to Carelon or through a billing intermediary. If using Change Healthcare as the billing intermediary, two identification numbers must be included in the 837 file for adjudication:

- Carelon's payer ID is 43324
- Carelon's health plan-specific ID045

### eServices

eServices enables providers to submit inpatient and outpatient claims without completing a CMS-1500 or UB-04 claim form. Given that much of the required information is available in Carelon's database, most claim submissions take less than one minute and contain few, if any, errors.

### Interactive Voice Recognition

Interactive Voice Recognition (IVR) provides telephone access to member eligibility, claim status and authorization status by telephone and is available for selected transactions at **855-481-7044**.

## Claim transaction overview

The following table identifies all claim transactions, indicates which transactions are available on each of the electronic media, and provides other information necessary for electronic completion. Watch for updates as additional transactions become available on EDI, eServices and IVR.

**TABLE 3-11 CLAIM TRANSACTION OVERVIEW**

| Transaction | Access | | | When applicable | Carelon receipt time frame | Other information |
|---|---|---|---|---|---|---|
| | EDI | eServices | Phone | | | |
| **Member eligibility verification** | Y | Y | Y | • Completing any claim transaction<br>• Submitting clinical authorization requests | N/A | N/A |
| **Submit standard claim** | Y | Y | N | Submitting a claim for authorized, covered services within the timely filing limit | Within 180 days of service date | N/A |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Resubmission of denied clam** | N | N | N | A first-time claim is received by Carelon after the original 180-day filing limit and must include evidence that one of the following conditions is met:<br>• Provider is eligible for retroactive reimbursement<br>• Member was retroactively enrolled in the health plan<br>• Services were retroactively authorized<br>• Third-party coverage is available and billed first (a copy of the third-party insurance EOB or payment is required) | Within 180 days of qualifying event | Waiver requests are only considered under specific circumstances:<br>All other requests result in a claim denial on a future EOB:<br>• A claim submitted beyond the filing limit that does not meet the above criteria may be submitted as a reconsideration request<br>• A Carelon waiver determination is reflected on a future EOB with a message of Waiver Approved or Waiver Denied: if waiver of the filing limit is approved, the claim shows as adjudicated; if denied, the denial reason appears. |
| **Request for reconsideration of timely filing limit** | Y | N | Y | Claim falls outside of all time frames and requirements for resubmission, waiver and adjustment. | Within 180 days from the day of payment or non-payment | Future EOB shows "Reconsideration approved" or Reconsideration denied" |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Request for adjustment (corrected claims)** | Y | Y | N | The amount paid to provider on a claim was incorrect. Adjustment may be requested to correct:<br>• Underpayment (positive request)<br>• Overpayment (negative request) | Positive Carelon request must be received within 180 days from original payment date.<br>No filing limit for negative requests. | Do NOT send a refund check to Carelon.<br>A rec ID is required to indicate that the claim is an adjustment.<br>Adjustments are reflected on a future EOB as recoupment of the previous (incorrect) amount and, if the provider is owed money, claim payment for the correct amount.<br>If an incorrect adjustment appears on an EOB, another adjustment request may be submitted based on the previous incorrect adjustment.<br>Denied claims may be resubmitted, but not adjusted. |
| **Obtain claim status** | N | Y | Y | Available 24/7 for all claim transactions submitted by provider. | N/A | Claim status is posted within 48 hours after receipt by Carelon. |
| **View/print remittance advice (RA)** | N | Ya | N | Available 24/7 for all claim transactions submitted by Carelon. | N/A | Printable RA is posted within 48 hours after receipt by Carelon. |

**NOTE:** Waivers and reconsiderations apply only to the claims filing limit; claims are still processed using standard adjudication logic and all other billing and authorization requirements must be met. Accordingly, an approved waiver or reconsideration of the filing limit does not guarantee payment since the claim could deny for another reason.

## Paper claim transactions

Providers are strongly discouraged from using paper claim transactions where electronic methods are available and should be aware that processing and payment of paper claims is slower than that of electronically submitted claims. Electronic claim transactions take less time and have a higher rate of approval since most errors are eliminated.

For paper submissions, providers are required to submit clean claims on the National Standard Format CMS-1500 or UB-04 claim form. No other forms are accepted.

Paper claims must be submitted using the most current form version as designated by the Centers for Medicare & Medicaid Services (CMS) and National Uniform Claim Committee (NUCC). We cannot accept handwritten claims or superbills.

Detailed instructions for completing each form type are available at the following websites:

- **CMS-1500 form instructions**
- **UB-04 form instructions**

Paper claims should be mailed to the following mailing address:

**Paper Claims**
Carelon Health Options Attention: Claims Department
P.O. Box 1870
Hicksville, NY, 11802-1870

## Electronic Claims

Claims may be submitted directly to Carelon via an 837 file or via the provider website (registration required).

Carelon Payer ID: 43324

Carelon does not accept faxed claims.

## Paper resubmission

Carelon discourages paper transactions. Paper submissions have more fields to enter, a higher error rate/lower approval rate, and slower payment. Find out how to submit claims electronically here.

- See Table 3-11 for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.
- If the resubmitted claim is received by Carelon more than 180 days from the date of service. The REC.ID from the denied claim line is required and may be provided in either of the following ways:
  - Enter the REC.ID in box 64 on the UB-04 claim form, or in box 19 on the CMS-1500 form
  - Submit the corrected claim with a copy of the EOB for the corresponding date of service
- The REC.ID corresponds with a single claim line on the Carelon EOB. Therefore, if a claim has multiple lines there will be multiple REC.ID numbers on the Carelon EOB.
- The entire claim that includes the denied claim line(s) may be resubmitted regardless of the number of claim lines; Carelon does not require one line per claim form for resubmission. When resubmitting a multiple-line claim, it is best to attach a copy of the corresponding EOB.
- Resubmitted claims cannot contain original (new) claim lines along with resubmitted claim lines.
- Resubmissions must be received by Carelon within 180 days after the date on the EOB. A claim package postmarked on the 180th day is not valid.
- If the resubmitted claim is received by Carelon within 180 days from the date of service, the corrected claim may be resubmitted as an original. A corrected and legible photocopy is also acceptable.

## Paper submission of 180-day waiver

1. See Table 2-2 for an explanation of waivers (when a waiver request is applicable) and procedural guidelines
2. Watch for notice of waiver requests becoming available on eServices.
3. Download the 180-day waiver form.
4. Complete a 180-day waiver form for each claim that includes the denied claim(s), per the instructions below.
5. Attach any supporting documentation.
6. Prepare the claim as an original submission with all required elements.

7. Send the form, all supporting documentation, claim and brief cover letter to:

**Carelon Health Options**
Attention: Claims Department
P.O. Box 1870
Hicksville, NY 11802-1856

## Completion of the waiver request form

To ensure proper resolution of your request, complete the 180-day waiver request form as accurately and legibly as possible.

1. **Provider name**
   Enter the name of the provider who provided the service(s).
2. **Provider ID number**
   Enter the ID number of the provider who provided the service(s).
3. **Member name**
   Enter the member's name and ID number.
4. **Contact person**
   Enter the name of the person whom Carelon should contact if there are any questions regarding this request.
5. **Telephone number**
   Enter the telephone number of the contact person.
6. **Reason for waiver**
   Place an "X" on all the line(s) that describe why the waiver is requested.
7. **Provider signature**
   A 180-day waiver request cannot be processed without a typed, signed, stamped, or computer-generated signature. Carelon will not accept "Signature on file."
8. **Date**
   Indicate the date that the form was signed.

## Paper request for adjustment or void

Paper submissions have more fields to enter, a higher error rate, lower approval rate and slower payment. Carelon discourages paper transactions.

**Before submitting paper claims, please review the electronic submission options described earlier in this chapter.**

- See Table 3-11 for an explanation of adjustments and voids, when these requests are applicable, and procedural guidelines
- Do not send a refund check to Carelon. A provider who has been incorrectly paid by Carelon must request an adjustment or void.
- Prepare a new claim with your desired final payment with all required elements; place the REC.ID in box 19 of the CMS-1500 claim form, or box 64 of the UB04 form.
- Download and complete the adjustment/void request form per the instructions below.
- Attach a copy of the original claim.
- Attach a copy of the EOB on which the claim was erroneously paid or for an incorrect amount
- Send the form, documentation and claim to:
  **Carelon Health Options**
  Attention: Claims Department
  P.O. Box 1870
  Hicksville, NY 11802-1856

## Completion of the adjustment/void request form

To ensure proper resolution of your request, complete the adjustment/void request form as accurately and legibly as possible and include the attachments specified above.

1. **Provider name**
   Enter the name of the provider to whom the payment was made.
2. **Provider ID number**
   Enter the Carelon ID number of the provider who was paid for the service. If the claim was paid under an incorrect provider number, the claim must be voided and a new claim must be submitted with the correct provider ID number.
3. **Member name**
   Enter the member's name as it appears on the EOB. If the payment was made for the wrong member, the claim must be voided and a new claim submitted.
4. **Member identification number**
   Enter the plan member ID number as it appears on the EOB. If a payment was made for the wrong member, the claim must be voided and a new claim submitted.
5. **Carelon Record ID number**
   Enter the record ID number as listed on the EOB.
6. **Carelon paid date**
   Enter the date the check was cut as listed on the EOB.
7. **Check appropriate line**
   Place an "X" on the line that best describes the type of adjustment/void being requested.
8. **Check all that apply**
   Place an "X" on the line(s) which best describe the reason(s) for requesting the adjustment/void. If "Other" is marked, describe the reason for the request.
9. **Provider signature**
   An adjustment/void request cannot be processed without a typed, signed, stamped, or computer- generated signature. Carelon will not accept "Signature on file."
10. **Date**
    List the date that the form is signed.

# Provider education of compliance-based training materials

Providers are expected to adhere to all training programs identified as compliance-based training by Humana and Carelon. This includes agreement and assurance that all affiliated participating providers and staff members are trained on the identified compliance material. This includes the following training modules:

- Provider orientation
- Medicaid provider orientation
- Cultural Competency (required annually)
- Health, Safety and Welfare Education (required annually)

Get information on:

- Humana's Cultural Competency Plan
- Humana's Health, Safety and Welfare Training
- Humana's Fraud, Waste and Abuse Training

Additional information on these topics is included in Humana's required annual compliance training as identified by Humana and Carelon. Please visit Carelon's provider website and click on "Tools" for help in understanding how to access this required training.

## Authorization guidelines (outpatient)

**Table 3-12 Authorization guidelines (outpatient)**

| Benefit/service | Authorization requirement | Other information |
|---|---|---|
| **Medication management (E/M)** | None | |
| **Psychiatric diagnostic interview with medical services** | None | |
| **Psychiatric diagnostic evaluation** | None | |
| **Injection administration** | None | |
| **Mental health/SA assessment** | None | |
| **Treatment plan development** | None | |
| **Group therapy** | None | |
| **Prenatal care at-risk assessment** | None | |
| **Individual psychotherapy** | None | |
| **Crisis intervention** | None | |
| **Family and marital therapy** | None | |
| **Medication administration** | None | |
| **Mental health risk assessment** | None | |
| **Case consultation** | None | |

# Section IV - Definitions

The following definitions are specific to this manual:

**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 state courts), relating to the provision of healthcare when the individual is incapacitated.

**Agency** – Illinois Department of Healthcare and Family Services (HFS)

**Appeal** – A request for review of an action, pursuant to U.S.42 CFR 438.400(b).

**Benefits** – A schedule of healthcare member services covered by the health plan as set forth in manual Section I.

**Children/adolescents** – Members younger than 21 (in most cases).

**Complaint** – A complaint is an informal component of the grievance system. Any oral or written expression of member dissatisfaction submitted to Humana or a state agency. Possible complaint subjects include, but are not limited to:

- The quality of care
- The quality of services provided
- Aspects of interpersonal relationships (such as provider or Humana employee rudeness)
- Failure to respect member rights
- Humana administration
- Claims, practices or provision of services related to the quality of provider care pursuant to Humana's contract

**Contract(s)** – The contract between U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) – in partnership with the Illinois Department of Human Services (HFS) — and Humana for the Medicare-Medicaid Alignment Initiative Demonstration (MMAI contract) regarding the provision of managed-care organization (MCO) health services.

**County health departments (CHD)** – CHDs are organizations administered by the state health department to promote public health, preventable disease control and eradication, and to provide primary healthcare for special populations.

**Covered service** – Aid provided by Humana in accordance with its Demonstration contract, and as outlined in manual Section II under "Covered services."

**Dual-eligible recipient** – Any recipient deemed entitled to receive medical or allied care, goods or services covered under the state's contracted program. Eligibility is determined by the state or Social Security Administration on behalf of the state, pursuant to federal and state laws.

**Consumer-directed (CD) model of services** – The delivery template through which the member, who is eligible to receive services through a waiver, (or the member's employer of record, as appropriate), is responsible for the hiring, training, supervising, and firing of those who actually render state-reimbursed services.

**Emergency medical condition** – A level of health manifested by symptoms (which may include pain or other signs of illness) so severe that a prudent layperson with average health and medical knowledge could reasonably expect that a lack of immediate medical attention could lead to:

- 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 pregnant women:

- Consideration of whether a transfer may pose a threat to the health and safety of the patient or fetus
- Examination of evidence of the onset and persistence of uterine contractions or rupture of other membranes

**Emergency services and care** – Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, other appropriate personnel under physician supervision, to determine whether an emergency medical condition exists. If an emergency condition exists, it includes the necessary available on-site treatment to relieve or eliminate the emergency medical condition.

**Value-added benefits** – A Humana-covered treatment for which Humana receives no direct agency payment.

**External quality review organization (EQRO)** – A group 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 either state or federal regulations, or both.

**External quality review (EQR)** – The analysis and evaluation by an EQRO of aggregated information on quality, timeliness and healthcare access furnished to Demonstration recipients by Humana.

**Grievance** – An expression of dissatisfaction about any matter other than an action. Possible grievance subjects include, but are not limited to, quality of care, provided services and aspects of interpersonal relationships (such as provider or provider employee rudeness), or failure to respect member rights.

**HFS** —The Illinois Department of Healthcare and Family Services and any successor agency. In this Contract, HFS may also be referred to as "Agency" or "the Department." HFS includes any person with which it may have a contract, or otherwise designate, to perform a HFS function under this Contract.

**Home and community-based services (HCBS) waiver** – Waivers under Section 1915(c) of the SSA that allow the State to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities.

**Health plan** – An entity that integrates financing, management and delivery of healthcare services to an enrolled population. It employs or contracts with an organized service provider system. A health plan also contracts with the state to provide Demonstration services, and includes health maintenance organizations (HMOs) authorized under the Illinois Health Maintenance Organization Act, (215 ILCS 125 et seq. of the Illinois statutes), exclusive provider organizations (EPOs) as defined in 50 Ill. Administrative Code 2051.220, and health insurers authorized under 215 ILCS 5/352 et seq. of the Illinois statutes.

**Licensed** – A facility, equipment or individual that meets formal state, county and local requirements.

**Mandates** – Applicable state and federal laws and regulations, including, without limitation:

- Medicaid and Medicare laws rules and regulations
- CMS requirements
- MMAI requirements and policies
- State and federal government sponsor orders, directives and requirements

**Medicaid** – The program under Title XIX of the SSA that provides medical benefits to eligible individuals, including certain people with low incomes.

**Medicaid dual-eligible reform** – MMAI changes resulting from 2013 CMS approval of joint plan implementation.

**Medical 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.

**Medically necessary or medical necessity**

This term refers to aid, supplies or medicines that:

- Are appropriate, reasonable and necessary for the diagnosis or treatment of illness or injury
- Improve the function of a malformed body part, or are otherwise medically necessary under 42 U.S.C.§1395y
- Are covered by the Illinois Department of Healthcare and Family Services
- Meet good medical practice standards in the medical community as determined by the provider:
  - Based on applicable standards of the care, diagnosis and treatment of a covered illness or injury in accordance with Demonstration plan guidelines, policies and procedures
  - As approved by CMS or the state
  - For the prevention of future disease

To assist in the member's ability to attain, maintain or regain functional capacity or achieve age-appropriate growth, plans provide coverage in accordance with the more favorable of the current Medicare and Department coverage rules, as outlined in state and federal rules and coverage guidelines.

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

**Member** – A Demonstration recipient currently enrolled in Humana.

**Non-covered service** – A service that is not a covered service or benefit.

**Nursing facility** – An institutional care facility that furnishes medical or allied inpatient care and services to individuals in need.

**Outpatient** – A patient of an organized medical facility or distinct part of that facility who receives (as expected by the facility) professional services for less than a 24-hour period without regard for admission hours, bed use or length of patient stay.

**Participating specialist** – A physician licensed to practice medicine in Illinois who contracts with Humana to provide specialized medical services to plan members.

**Patient-centered medical home (PCMH)** – A healthcare setting that facilitates partnerships between individual patients, personal physicians and, when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchanges and other means to ensure that patients receive the needed indicated care when and where desired and in a culturally and linguistically appropriate manner. Participating PCMHs are required to manage and provide evidence-based services to members to integrate care with specialty and subspecialty practices.

**Patient pay** – The amount of the long-term services and supports (LTSS) member's income which must be paid as their share of the LTSS services expense.

**Primary care** – Comprehensive, coordinated and readily accessible medical care including health promotion and maintenance, illness and injury treatment, early detection of disease and specialist referral when appropriate.

**Primary care provider (PCP)** – A Humana staffer or contracted physician practicing as a general or family practitioner, internist, pediatrician or other state-approved specialty, who furnishes primary member care and patient management services. Pregnant members with chronic health conditions, disabilities or special healthcare needs may request that specialty or provider medical homes that furnish primary care and patient management services be designated as their PCP. Homebound members or members with significant mobility limitations may request that primary care services be furnished by nurse practitioners or physicians through home visits.

**Preauthorization** – Humana approval of specific services before they are rendered.

**Protocols** – Written guidelines or documentation outlining actions for handling a particular situation, resolving a problem, or implementing a plan of medical, nursing, psychosocial, developmental and/or educational services.

**Provider** – A person or entity that meets all state and/or federal requirements (as appropriate) to provide covered services to Demonstration members.

**Participating provider (or network provider)** – A contracted healthcare provider who is under a currently valid provider agreement to participate in a Humana's Medicare Advantage and/or Medicaid networks serving Demonstration members.

**Provider contract** – An agreement between Humana and a provider as described above.

**Quality** – The degree to which Humana increases the likelihood of desired member health outcomes through structural and operational plan characteristics and the provision of health services that are consistent with current professional knowledge.

**Quality Improvement (QI)** – The process of monitoring and ensuring that available, accessible, timely, medically necessary member healthcare and need-appropriate services is provided in sufficient and acceptable quantity and quality, and within established excellence standards.

**Quality Improvement Program (QIP)** – The process of ensuring delivery of appropriate, timely, accessible, available and medically necessary healthcare.

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

**State** – State of Illinois.

**Subcontract** – An agreement entered into by Humana for provision of administrative services on its behalf.

**Subcontractor** – Any person or entity with which Humana has contracted or delegated some of its state- contracted functions, services or responsibilities for providing services.

**Transportation** – An appropriate means of member-needed conveyance to obtain plan-covered services.

**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 substantially restrict member activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

**Well-care visit** – A routine medical visit for one of the following: family planning, routine follow-up for previously treated conditions or illnesses, adult physicals or any routine visit for other-than-illness treatment.