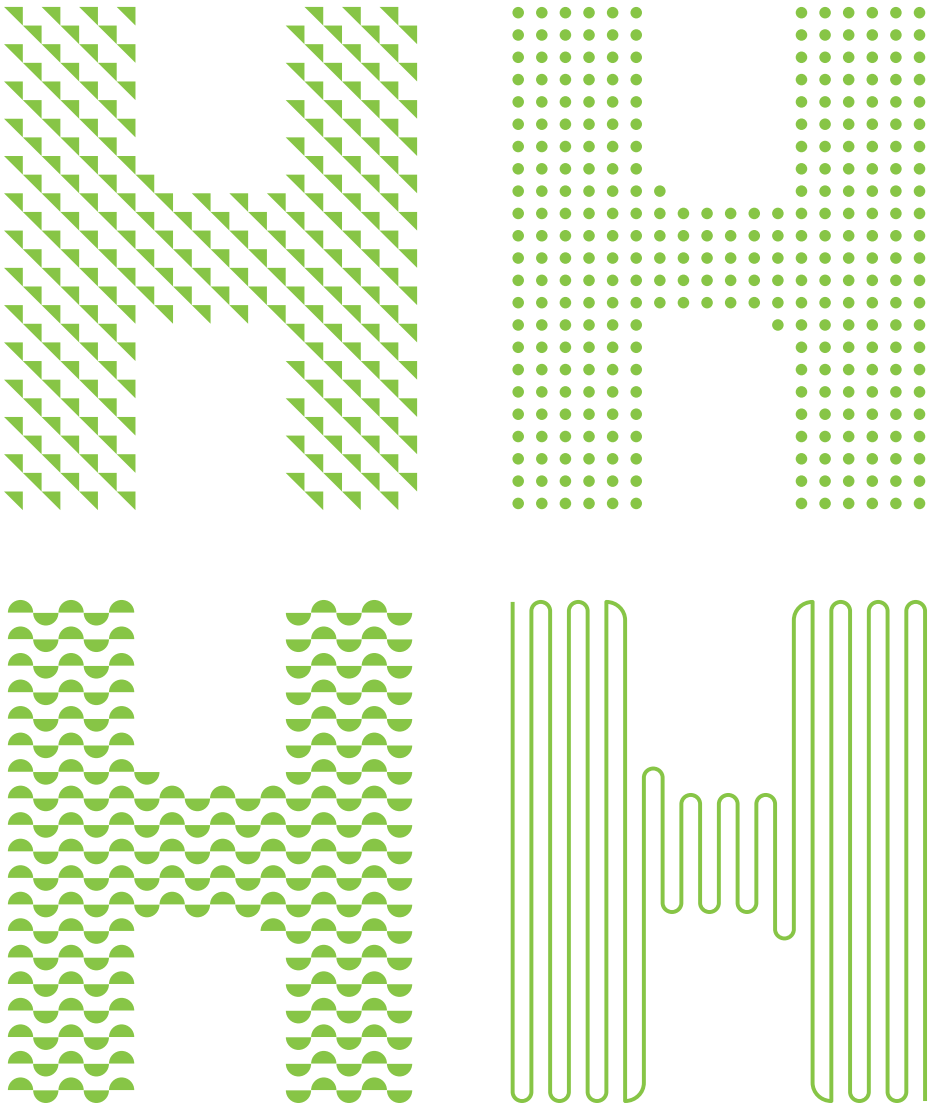

2025 Provider Manual

ILLINOIS—HUMANA GOLD PLUS INTEGRATED MEDICARE-MEDICAID

Humana®

Humana Gold Plus® Integrated Medicare-Medicaid is a health plan
that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to members.

587802IL1124 ILHLPEJEN1024

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 Illinois Demonstration program's purpose
- What you can expect from Humana and Carelon, the behavioral health provider network
- What we need from you

The guidelines outlined in this manual are designed to help you provide caring, responsive service to our Humana Gold Plus® Integrated Medicare-Medicaid 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,

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 dual-eligible Illinois beneficiaries. Jointly administered by the Centers for Medicare & Medicaid Services (CMS) and the Illinois Department of Healthcare and Family Services (HFS), the Medicare-Medicaid Alignment Initiative (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 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 community-based systems
- Eliminate cost shifting between Medicare and Medicaid

The following information is intended as an orientation and guide for the provision of covered services to Humana members and features policies, procedures and general reference information including minimum standards of care required of Humana providers. This information serves as a reference source for the statutes, regulations, telephone access and special requirements to ensure all requirements of a government-sponsored contract are met

Humana may choose not to distribute this information via surface mail, instead giving you written notification explaining 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.

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

Note: Manual Section I applies to all Demonstration providers. For additional details related to LTSS providers, please see Section II. For additional details related to behavioral healthcare 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 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 an in-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 that follow. 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 for specialty, LTSS and behavioral healthcare, as necessary.

Table 1-1 Covered plan services (general)

$0 memeber copay

Abdominal aortic aneurysm screening

Humana will cover a 1-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 (e.g., not associated with metastatic, inflammatory or infectious disease)
- Not associated with surgery
- Not associated with pregnancy

Humana will pay for an additional 8 sessions if the member shows improvement. The member may not receive more than 20 acupuncture treatments each year. Acupuncture treatments must be stopped if there is no improvement.

Alcohol misuse screening and counseling

Humana covers 1 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 4 brief, face-to-face counseling sessions each year (if the member is able and alert during counseling) with a qualified primary care provider (PCP) in a primary care setting.

Ambulance services

Humana covers ambulance services, whether for an emergency or nonemergency situation, including 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. Humana must approve other cases for ambulance services.

In nonemergency cases, 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 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 can be provided for up to 30 days following an MCR event to prevent additional behavioral health crises. To access MCR services, members should call the Crisis and Referral Entry Services (CARES) line, the state's crisis intake line, at **800-345-9049**. If using a TTY, call **866-794-0374**. CARES will dispatch a local provider to the location of the Humana member in crisis. Humana will cover MCR and crisis stabilization services provided by:

- Community mental health centers (CMHCs) with state crisis certification
- Behavioral health clinics (BHCs) 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 provider to review and comment on the results.

Mammograms

Humana covers the following services:

- 1 baseline mammogram between the ages of 35 and 39
- 1 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 provider's referral. Humana also covers intensive cardiac rehabilitation programs.

Cardiovascular disease risk reduction visit (heart disease therapy)

Humana covers 1 PCP visit per year to help lower heart disease risks. During this visit, the PCP may:

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

Cardiovascular disease testing

Humana covers blood tests to check for cardiovascular disease once every 5 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 PCP, 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:

- Colonoscopy—no age limits
  - Once every 120 months (10 years) for non-high-risk patients
  - 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer
  - 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 non-high-risk patients 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 once every 3 years for patients 45–85 who do not meet high-risk criteria
- Blood-based biomarker tests for patients 45–85
  - Once every 3 years who do not meet high-risk criteria
- Barium enema as an alternative to colonoscopy for high-risk patients and 24 months since the last screening barium enema or the last screening colonoscopy
- Barium enema as an alternative to flexible sigmoidoscopy for non-high-risk patients 45 years or older
  - Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy

Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare-covered, noninvasive, stool-based colorectal cancer screening test returns 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:

- 2 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:

- 2 quit counseling attempts within a 12-month period

For pregnant tobacco-using members, Humana covers:

- 3 quit counseling attempts within a 12-month period

Note: Each counseling attempt includes up to 4 face-to-face visits.

Dental services

Humana covers:

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

The following additional dental benefits are covered:

- 1 oral exam every 6 months
- 1 prophylaxis cleaning every 6 months

Depression screening

Humana covers 1 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
- History of abnormal cholesterol and triglyceride levels (dyslipidemia)
- Obesity
- History of high blood 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 2 diabetes screenings every 12 months.

Diabetic self-management training, services and supplies

Humana covers the following services for all members who have diabetes:

- Blood glucose monitoring supplies
  - 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
  - 1 pair of therapeutic custom-molded shoes, including 2 extra pairs of inserts each calendar year
  - 1 pair of depth shoes and 3 pairs of inserts each year, not including the non-customized removable inserts provided
- Fitting for therapeutic, custom-molded shoes or depth shoes
- Training to help members manage their diabetes, in some cases

Emergency care

Emergency care includes services:

- Given by a provider trained to give emergency services
- 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 without 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 the health of the member's unborn child
- Serious harm to bodily functions
- Serious dysfunction of any bodily organ or part
- In the case of a pregnant member in active labor:
  - Insufficient time to safely transfer the member to another hospital before delivery
  - Conditions where 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 the condition has stabilized, the member must return to an in-network hospital for continued care to be eligible for Humana coverage. Only plan approval permits a member to remain in the out-of-network hospital for inpatient care.

Family planning services (preauthorization required for infertility and genetic testing)

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

- Humana covers:
- Family planning exams and medical treatment
- Family planning lab and diagnostic tests
- Family planning methods (e.g., birth control pills, patch, ring, intrauterine device, injections, implants)
- Prescribed family planning supplies (e.g., condom, sponge, foam, film, diaphragm, cap)
- Infertility diagnosis, counseling and related services
- Counseling and testing for sexually transmitted infections (STIs), AIDS and 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 network provider for:

- 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 preauthorization and referral requirements.

Health and wellness education programs

Humana provides:

- 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 (OP) care when conducted by a physician, audiologist, or other qualified provider.

Humana covers:

- Basic and advanced hearing tests
- Hearing aid counseling
- Hearing aid evaluation and fitting
- Hearing aids every 3 years
- Hearing aid batteries and accessories
- Hearing aid repair and replacement parts

HIV screening

Humana covers 1 HIV screening every 12 months for members who:

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

For pregnant members, Humana covers up to 3 HIV screening tests during pregnancy.

Home health agency care

Before receiving home health services a provider must confirm member need, and those services must be provided by a home health agency (HHA). Humana covers:

- 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 8 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 medications or biological substances administered intravenously or subcutaneously and provided to members at home. The following are needed to perform home infusion:

- The medication or biological substance (e.g., an antiviral or immune globulin)
- Equipment (e.g., a pump)
- Supplies (e.g., tubing or a catheter)

Humana covers home infusion services including:

- Professional services, including nursing services, provided in accordance with the member's care plan
- Member training and education not already included in the durable medical equipment (DME) benefit
- Remote monitoring
- Monitoring services for the provision of home infusion therapy and home infusion medication 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 does not pay for those member services.

A terminal illness is defined as the determination that a member has 6 months or fewer to live. The hospice provider can be in- or out-of-network.

Humana covers the following while members receive hospice services:

- Medication 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 covers 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 medication that may be covered by Humana Gold Plus Integrated Medicare Part D benefit, medication is 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, Monday – Friday, 7 a.m. – 7 p.m., Central time. Our automated phone system may answer after hours, weekends and holidays. Members must provide their name and telephone number, and a coordinator should respond by the end of the next business day. Visit our website for 24-hour access to Humana's drug list for providers (https://provider.humana.com/pharmacy-resources/tools/humana-drug-lists). Information such as claims history and eligibility are available via Availity Essentials™. Members can obtain health news and information and use the Find a doctor tool via https://finder.humana.com/finder/medical?customerId=1.

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

Immunizations

Humana covers:

- Pneumonia vaccines
- Flu/influenza vaccines, once each flu/influenza season, in the fall and winter, with additional flu/influenza vaccinations if medically necessary
- COVID-19 vaccines
- Hepatitis B vaccines if members are at immediate/high risk
- 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 may be required)

Note: Members must receive plan approval to continue receiving inpatient care at an out-of-network hospital after an emergency condition has been stabilized. Services Humana covers include:

- Semi-private room or a private room if medically necessary
- Regular nursing services
- Medications
- X-ray and other radiology services
- Necessary surgical and medical supplies
- Provider services
- Inpatient substance use services
- Meals, including special diets
- Special care units (e.g., intensive or coronary care units)
- Lab tests
- Appliances (e.g., 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. 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 provides transplant services at a location outside the pattern of care for transplants in the member's community and the member chooses to obtain transplants at this distant location, Humana arranges or pays for appropriate lodging and transportation costs for the member and 1 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 stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient 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:

- Provider services
- Diagnostic tests (e.g., 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; and artificial legs, arms and eyes
  - Includes adjustments, repairs and replacements needed due to breakage, wear, loss or a change in the patient's condition
- Physical, speech and occupational therapy

Kidney disease services and supplies

Humana covers:

- Kidney disease education services to teach kidney care and help members make good decisions about their care
  - Members must have stage IV chronic kidney disease and a provider referral.
  - Humana covers up to 6 sessions of kidney disease education services.
- OP 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, including training for you and anyone helping the member with their home dialysis treatments
- Home dialysis equipment and supplies
- Certain home support services (e.g., trained dialysis worker visits to check home dialysis equipment and water supply and help during emergencies)

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

Lung cancer screening

Humana covers lung cancer screening every 12 months if a member:

- Is 50–77 years old
- Has counseling and shared decision-making with a qualified provider
- Has smoked at least 1 pack a day for 30 years with no signs or symptoms of lung cancer or:
  - Is a current smoker
  - Has quit within the past 15 years

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

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
- DME 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, continuous positive airway pressure (CPAP) and bilevel positive airway pressure (BIPAP) equipment
- DME, prosthetic and orthotic device repair
- Rental of medical equipment under circumstances where the patient's needs are temporary

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

Medical nutrition therapy

This benefit is for members with diabetes or kidney disease without dialysis. Members can also use this benefit after a kidney transplant when referred by a provider.

Humana covers 3 hours of one-on-one counseling services during the member's first year of medical nutrition therapy services under Medicare (includes Humana and any other Medicare Advantage [MA] plan) and 2 hours of one-on-one counseling services each successive year.

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

Medicare diabetes prevention program

Humana covers 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 covers:

- Medications injected or infused while members receive provider services
- Medications that use plan-authorized DME (e.g., nebulizers)
- Self-administered clotting factor injections for members with hemophilia
- Immunosuppressive medication for Medicare Part A-enrolled members at the time of organ transplant
- Injected osteoporosis drugs for homebound members with a bone fracture related to post-menopausal osteoporosis that cannot be self-injected, as certified by a provider
- Antigens
- Certain oral anticancer and antinausea medication
- Certain oral ESRD drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it (e.g., Epogen® or Procrit®)
- IV-immune globulin for home treatment of primary immune deficiency diseases
- Insulin furnished through an item of DME (such as a medically necessary insulin pump)
- Other drugs the member takes using DME (such as nebulizers) that were authorized by the plan
- The Alzheimer's drug, Leqembi (generic lecanemab), which is given intravenously (IV)
- Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv and the oral medication Sensipar
- Chemotherapy drugs and administration

Nonemergency transportation

Humana covers member transportation to or from medical appointments. Types of nonemergency transportation include:

- Nonemergency ambulance
- Shared-service car
- Taxi

Unlimited round trips per year by taxi, bus, subway, passenger van or medical transport are covered when traveling to nursing homes, pharmacies when immediately following provider visits, and other medical providers and locations.

Preauthorization 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 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 can purchase over-the-counter (OTC) health and wellness products available through CenterWell®, Humana's mail-order pharmacy.

HumanaFirst® nurse advice line

Members with symptom questions and concerns can call HumanaFirst, our nurse 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 covers:

- A semi-private or private room, maintenance, and cleaning
- Meals, including special meals, food substitutes and nutritional supplements
- Nursing services and resident supervision/oversight
- Provider services
- Physical, occupational and speech therapy
- Provider-ordered medications available through a pharmacy without a prescription as part of the member's plan of care, including self-administered OTC medication
- Non-custom DME (e.g., wheelchairs and walkers)
- Medical and surgical supply items, including bandages, oxygen administration supplies, oral care supplies and equipment, and 1 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-network payment amounts. Applicable situations include:

- A nursing home or continuing care retirement community where the member lived before their hospital stay, if it provides nursing facility care
- A nursing facility where the member's spouse lives after the member's hospital release
  - Preauthorization 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 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 of 30 or greater may receive weight loss counseling. Counseling must be provided 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:

- Intake activities
- Periodic assessments
- Medications approved by the Food and Drug Administration and, if applicable, managing and giving you these medications
- Substance use counseling
- Individual and group therapy
- Toxicology testing

OP diagnostic tests and therapeutic services

Humana covers:

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

Preauthorization and/or referral may be required.

OP hospital services

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

Humana covers:

- Emergency department or OP clinic services (e.g., observation services or OP surgery)
  - Sometimes a member can be in the hospital overnight and still be classified as "outpatient."
- Labs and diagnostic tests billed by the hospital
- Mental healthcare, including care in a partial-hospitalization program, if a provider certifies 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 screenings
- Some medication that cannot be self-administered, including:
  - Nuclear medicine services
  - Radiation therapy

Preauthorization and/or referral may be required.

OP mental healthcare

Humana covers mental health services provided by:

- State-licensed psychiatrists or healthcare providers
- Clinical psychologists
- Clinical social workers
- Clinical nurse specialists
- NPs
- PAs
- Licensed clinical professional counselors
- CMHCs
- 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:

- Clinic services under the direction of a provider
- Rehabilitation services recommended by a provider, including integrated assessment and treatment planning, crisis intervention, therapy, and case management
- Day treatment services
- OP hospital services, including 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.

OP mental health crisis services (expanded)

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

- MCR for crisis symptom reduction, stabilization and restoration to the previous level of functioning
  - MCR services require 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, members should call CARES at **800-345-9049 (TTY: 866-794-0374)**. CARES dispatches a local provider to the location of the member in crisis.
- Crisis stabilization services as 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:

- CMHCs with a crisis certification from the state
- BHCs with a crisis certification from the state

OP rehabilitation services

Humana covers physical therapy, occupational therapy and speech therapy.

Rehabilitation services are available from hospital OP departments, independent therapist offices, CORFs and other facilities. Preauthorization and/or referral may be required.

OP surgery

Humana covers OP surgery and services at hospital OP facilities and ambulatory surgical centers. Preauthorization and/or referral may be required.

Partial hospitalization services

Partial hospitalization is defined as a structured program of active psychiatric treatment offered in an OP hospital setting or by a CMHC. To prevent inpatient hospital stays, it offers a more intense level of care compared to the member's provider or therapist office.
Preauthorization and/or referral may be required.

Provider services including office visits

Humana covers:

- Medically necessary healthcare or surgery services provided in a:
  - Provider's office
  - Certified ambulatory surgical center
  - Hospital OP department
- Specialist consultation, diagnosis and treatment
- Hearing and balance exams ordered by a PCP
- Telehealth services for monthly 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 had an in-person visit within 6 months prior to the first telehealth visit.
  - The member has an in-person visit every 12 months while receiving telehealth services.
  - Exceptions can be made for certain circumstances.
- Telehealth services for mental health services provided by rural health clinics and FQHCs

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
- The check-in is unrelated to an office visit made within the past 7 days
- The check-in doesn't lead to an office visit within 24 hours or earliest-available appointment

- Consultation among providers by phone, over the internet or electronic health record (EHR) if the member is not a new patient
- Second opinions before a medical procedure from a network provider
- Non-routine dental care 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
  - Services that would be covered when provided by a healthcare provider

Preauthorization and/or referral may be required.

Podiatry services

Humana covers:

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

Members seeking treatment for the above are covered for additional podiatry benefits and may self-refer to a network specialist for up to 6 visits each year. This includes:

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

Preauthorization 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 4 discharges per year. Please call Humana Well Dine® at **866-96-MEALS (866-966-3257) (TTY: 711)** for further details.

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

Humana covers:

- Colostomy bags and related supplies
- Pacemakers
- Braces
- Prosthetic shoes
- Breast prostheses, including a surgical brassiere following a mastectomy
- Artificial arms and legs
- Testing, fitting, or training in the use of prosthetic and orthotic devices

Humana also covers some supplies related to prosthetic devices and prosthetic device replacement or repair. Humana offers some coverage after cataract removal or cataract surgery.

Preauthorization and/or referral may be required.

STI screening and counseling

Humana covers the following screenings for pregnant women at certain times during pregnancy and for members at risk for STIs once every 12 months:

- 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.

Smartphone services

With a smartphone, members have easy access to health-related information and can stay connected to their care team and health plan. Any member who qualifies for the federal Lifeline program will be eligible to receive a free smart phone with monthly talk minutes, text and data.

Substance use services

Humana covers substance use services provided by:

- State-licensed substance abuse facilities
- Hospitals

Humana covers:

- Group or individual OP 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 OP services, group or individual
- Detoxification services
- Some residential services, such as short-term rehabilitation services

Supervised exercise therapy

Humana covers supervised exercise therapy (SET) for members with symptomatic peripheral artery disease (PAD) with a referral from their PAD healthcare provider. Humana covers:

- 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
- Delivered in a hospital OP setting or in a provider's office
- Delivered by qualified personnel who ensure benefit exceeds harm and are trained in exercise therapy for PAD
- Performed under the direct supervision of a physician, PA or NP/clinical nurse specialist trained in both basic and advanced life support techniques

Transplant services

The Humana transplant services team helps members and their providers 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**, Monday – Friday, 7 a.m. – 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 nonemergency
- A sudden medical illness
- An injury
- 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:

- Annual routine eye exams
- Eyeglasses (lenses and frames)
  - Frames limited to 1 pair in a 24-month period
  - Lenses limited to 1 pair in a 24-month period; members may get more when medically necessary, with preauthorization
- Custom-made artificial eye
- Low vision devices
- Contacts and special lenses when medically necessary, with preauthorization

To be eligible for reimbursement, some services may be subject to preauthorization and/or medical criteria.

Humana covers OP provider 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 1 glaucoma screening each year for people at high risk of glaucoma, including:

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

Humana covers 1 pair of glasses or contact lenses after each cataract surgery when the provider inserts an intraocular lens. If the member has 2 cataract surgeries, the member must get 1 pair of glasses after each surgery. The member cannot get 2 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 1-time "Welcome to Medicare" preventive visit. The visit includes:

- Member health review
- Necessary member preventive service education and counseling, including screenings and vaccinations
- 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 an appointment.

Excluded benefits

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. The following benefits are excluded:

- Services not considered 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 those for 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 correct a physical malformity.
  - Humana covers breast reconstruction after a mastectomy.
- Preventive dental care
  - Refer to the dental services topic for more information.
- Naturopath services
- 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
- Radial keratotomy, LASIK surgery and vision therapy
- Reversal of sterilization procedures
- Partial dentures

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

Utilization Management

Our Utilization Management (UM) program ensures 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 covered benefits, medically necessary and appropriate for the member's condition
- Are provided at the most appropriate level of care

Preauthorization

Preauthorization is defined as a process through which the 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 healthcare provider notifying Humana of the intent to provide an item, drug or service. Humana may request notification because it helps coordinate care. This process is distinguished from preauthorization since it does not result in an approval or denial.

Providers should access preauthorization lists online to determine what medications and/or services require preauthorization

- Select the current "Humana Gold Plus Integrated Illinois Dual Medicare-Medicaid Plan Preauthorization and Notification List"

From here you can select and view the respective 2025 medical or 2025 medication preauthorization lists

You also can call Humana MMAI Provider Services at **800-787-3311** to request a hard copy of the list. 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 of initiation of these services.

If preauthorization is required and not obtained, the result may be 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 preauthorization

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

- Visit Availity Essentials at www.availity.com (registration required).
  - For many services, you can answer a series of questions when requesting the preauthorization. If approved, you will receive notification immediately. If your request is pending 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 electronic data interchange (EDI).
- Call our interactive voice response (IVR) system at **800-523-0023**, Monday – Friday, 7 a.m. – 7 p.m., Central time.
- Call the number for preauthorization on the back of the patient's member ID card.
- Fax the request to 855-227-0677.

If a request must be expedited due the seriousness of a patient's condition, call **800-523-0023**, Monday – Friday, 7 a.m. – 7 p.m., Central time.

Required information for a preauthorization request or notification

Information required for a preauthorization request or notification may include:

- Member's Humana ID number, name and date of birth
- Date of actual service or hospital admission
- Procedure codes, up to 10 maximum per preauthorization request
- Date of proposed procedure, if applicable
- Diagnosis codes, primary and secondary, up to 6 maximum per authorization request
- Service location
- Inpatient location (e.g., acute hospital, skilled nursing, hospice)
- OP location (e.g., telehealth, office, home, off-campus outpatient hospital, on-campus outpatient hospital, ambulatory surgery center)
- Referral (e.g., 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 provider's telephone number
- Relevant clinical information
- Discharge plans

Submitting all relevant clinical information at the time of the request facilitates 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 PCP, the patient can be referred to a specialist for consultation and/or treatment. Humana contracts with specialists in the plan's service area. See the Humana claims payment website for more information about ordering provider and referring provider requirements. Referrals are not required to see some specialists, such as OB-GYN.

The PCP initiates the referral by submitting a referral request through Availity Essentials. Methods for submitting referral requests are outlined in the preauthorization section above and on Humana.com/PAL. The PCP receives a referral number from Humana if the referral request is completed, and Humana determines the services are covered under the provider agreement; provided by an approved provider/facility; and 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 visiting www.availity.com or by calling **800-523-0023**, Monday – Friday, 7 a.m.

– 7 p.m., Central time. 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 can be found at Provider.humana.com/coverage-claims/prior-authorizations/prior-authorization-lists under the Medicare tab or by calling **800-4HUMANA (800-448-6262)** 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 acute inpatient facility, SNF, long-term acute care hospital 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 preventing 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 UM 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 provider. 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 member and the member's family or guardian, the hospital's UM and discharge planning departments, and the member's attending 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 UM 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 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 calling 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 ordering provider may be given an opportunity to discuss the services 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 rendering of the adverse determination. Once an adverse determination is made, participating providers will have the opportunity to submit a provider dispute. A participating provider may submit a dispute before submitting a claim if Humana's adverse determination was based on lack of medical necessity for an authorization request that was retrospective or concurrent to the service.

Providers have 5 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 before the adverse determination. Participating providers also can submit claim disputes via the outlined claim appeals 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, or necessity for:

- Surgical procedures
- Treatment for a serious injury or illness
- Situations in which members feel 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 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 2 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 at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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, the hospital and provider determine inpatient care is no longer necessary.

Guidelines for IM notification by telephone

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

- The name and telephone number of a contact at the hospital
- The member's planned discharge date and the date when liability begins
- The member'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 provider believe the member is ready to be discharged
- A description of the steps for filing an appeal
- 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 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 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 the documentation indicates the staff person told the member or representative the planned discharge date, the date the member's financial liability begins, the member'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 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).

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 noon 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, the member 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 at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Medicare Outpatient Observation Notice 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

- Hospitals and CAHs are responsible to provide the written MOON and a verbal explanation of the notice to all Original Medicare and MMAI members who receive outpatient observation services for more than 24 hours.
- The MOON must be provided to the member or the member's authorized representative no later than 36 hours after observation services begin and may be delivered before a member receives 24 hours of observation services as an outpatient.
- If the member 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 provider's order.
- Hospitals and CAHs must use the Office of Management and Budget-approved MOON (CMS-10611) and instructions available on the CMS website at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative.

Additional information about the MOON can be found on the CMS Medicare Learning Network site at www.cms.gov/newsroom/fact-sheets/medicare-outpatient-observation-notice-moon.

Special requirements for SNFs, HHAs and CORFs

Medicare Advantage (MA) plan members

CMS requires healthcare providers give the Notice of Medicare Non-Coverage (NOMNC) to MA/MMAI Humana members at least 2 days before termination of SNF, HHA or CORF services. Additionally, if the member's SNF services are expected

to be fewer than 2 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 penultimate 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 at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative.

Providers also can contact their QIO for forms or additional information. Forms can be obtained from Humana's local health services UM 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 and the member must receive all required notifications. The following specific information must 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 member'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 all of the previous information was included in the communication. The annotated NOMNC 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 UM department.

Right to appeal an 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, including 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 at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative.

Emergency service responsibilities

Emergency services

Participating providers are required to ensure adequate accessibility for healthcare 24 hours a day, 7 days a week. An after-hours telephone number must be available to members. Voicemail alone is not acceptable.

Members should go to the closest emergency room (ER) or any other emergency setting if they experience symptoms including:

- 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 provider 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 ER or setting. In such situations, the member's PCP should be contacted as soon as possible.

Emergency behavioral 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 ER or any other recommended emergency setting. Emergency behavioral health conditions include:

- Becoming a danger to self or others
- Inability to carry out actions of daily life due to 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 and psychosocial issues, and LTSS. It is aimed at eliminating fragmented, poorly coordinated healthcare and social services, which can result in poor health outcomes and inefficient expenditures.

Humana's model of care focuses on member experience and provides appropriate utilization of services, ensuring cost-effective health services delivery.

The provider's participation is key and includes:

- Participation in interdisciplinary care team (ICT) care conferences via phone and exchange of written and in-person communications
- Participation in communications to foster care coordination
- Promotion of Healthcare Effectiveness Data and Information Set (HEDIS®) and National Committee for Quality Assurance (NCQA) quality measures
- Providing 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 and LTSS providers. Nonparticipating 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 members are informed of specific follow-up healthcare needs and members receive training in self-care including medication adherence and other measures to promote their health
- Ensuring members receive necessary appropriate specialty, ancillary, emergency and hospital care
- Providing necessary referrals and communication to specialists, hospitals, SNFs and other providers
- Providing information to assist 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 NPs or other qualified providers
- Tracking and documenting member appointments, clinical findings and treatment plans to ensure continuity of care from referred specialists and other healthcare providers
- Obtaining preauthorization and notifying 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 exams with qualified in-network healthcare professionals
- Providing member help with arranging a second opinion visit with a nonparticipating 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 obtaining appropriate preauthorization if using out-of-network facilities
- Cooperating and communicating with other member service providers, including Supplemental Nutrition Programs for Women, Infants and Children (WIC), Head Start programs, early intervention programs and school systems.
  - Cooperation may include performing annual physicals for school and sharing information with member consent.
- Supporting and communicating with the ICT 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 responding to recommendations for improvement by developing and enacting a corrective/improvement plan
- Following the 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
- Acknowledging out-of-network or other preauthorization is 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 provider 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 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 the 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 quality assurance requirements.
- Provide necessary medical information.
- Adhere to Humana's policies and procedures, including procedures regarding referrals.

If the provider of a new member who is 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 provider for up to 90 days or through the postpartum period, or as otherwise required by Section 25 of the Managed Care Reform and Patient Rights Act, only if the out-of-network provider 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
- CT-developed member plans
- Inclusion of member-driven short- and long-term goals, objectives, and interventions
- Need to address 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 the member's family.

Provider participation is an integral part of the ICT. Other team members may include:
- The member and/or the member's authorized caregiver
- The member's other healthcare providers
- 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 provider-inclusive ICT model supports the following:
- Provider treatment and medication plans
- Provider goals via the Humana care management team of nurses, social workers, pharmacy and behavioral health specialists
- Member education and enhancement of direct patient-provider 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 2 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 specialists, 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 EHRs.

Note: Additional member information will be added regarding care plans, assessments and member summaries and made available through Availity Essentials at www.availity.com.

When working with Demonstration members with a behavioral health diagnosis:

- Facilitate appropriate member referral to specialists or specialty care, behavioral healthcare services, health education classes and community resource agencies.
- Integrate medical screening and basic primary care services.
- 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 risk for poor outcomes and functional limitations as well as high-cost services such as hospitalizations and ER visits. Preventive and consistent care of chronic conditions reduces the advent of major conditions and decreases ER visits and readmissions.

Humana's clinical practice guidelines, available at Provider.Humana.com/patient-care/guidelines, incorporate relevant, evidence-based medical and behavioral health guidelines from recognized sources including professional medical associations, voluntary health organizations, and National Institutes of Health (NIH) centers and institutes.

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

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

- Member-centered, coordinated care (person-centered, collaborative care, managed by a team with knowledge about specific member needs and the array of medical, nonmedical and behavioral services and benefits available to meet those needs) is critical to helping members achieve their optimum health.
- Many dual-eligible members require a broad range of LTSS and community support to meet their functional needs. Effective coordination, administration and easy access to LTSS benefits help ensure these needs are adequately met and reduce 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 explanation of remittance, automated remittance advice or remittance advice, providers disagree with Humana's determination, they may request a dispute/reopening of the issue.

Nonbehavioral health provider disputes

Providers may submit disputes online or by contacting Humana via telephone, mail 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 Provider.Humana.com/working-with-us/web-based-training.

Telephone

Provider disputes may be submitted by calling **800-787-3311**, Monday – Friday, 7 a.m. – 7 p.m., Central time. Follow the prompts to provide the claim ID for the disputed claim, then you may request to file a claim dispute. You will be transferred to a specialized associate who can assist you.

Mail

Send written disputes to:

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

Fax

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

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

- 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 managed care organization (MCO) tracking number for each complaint submitted through the Humana internal dispute process. Disputes submitted by phone 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 2 to 3 business days for a tracking number to be generated before 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 MMAI Provider Services at **800-787-3311**, Monday – 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 Humana sends in response to the claim dispute. Find the MCO tracking number—identified as "Reference ID"—in the header of the outcome letter.

Behavioral health provider disputes

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

Telephone

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

Email

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

Fax

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

Disputes submitted over the phone will not automatically generate a reference number if provider services can address the complaint during the call. However, a tracking number can always be provided if requested.

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

If a dispute is received via fax and includes the provider's phone number, Provider Services will call with the MCO tracking number. If a phone number was not included, Provider Services will send a fax acknowledging the receipt of the 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, you can refer to the complaint acknowledgement letter sent in response to the claim dispute. Find the MCO tracking number (reference ID) in the header.

Provider disputes submitted to the Illinois HFS

Providers can submit complaints regarding unresolved issues with Humana via the HFS Managed Care Provider Resolution Portal at https://hfs.illinois.gov/medicalproviders/cc/managedcarecomplaints.html. Humana is responsible for the timely and complete resolution of provider complaint tickets uploaded to the 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:

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

All portal submissions must include the MCO-assigned tracking number and the date the complaint was filed with Humana's internal dispute resolution process. 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 a written proposal to resolve the dispute, unless HFS grants Humana a 30-day extension. Providers are notified if an extension is granted via the portal.

Providers must use the new standard complaints/claims-issue template when submitting 2 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 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 HFS to review and make a final decision. The HFS decision on all disputes is final.

Grievances and appeals system

The information that follows is supplied to help you assist Humana members with the grievances and appeals 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 (TTY: 711)**. 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 can 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, 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 of 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.

Providers can request an expedited appeal by calling Humana MMAI Provider Services at 800-787-3311, Monday – 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 mail it to:

Humana Medical Plan Inc.
Attn: Grievances 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 at ww.availity.com. 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 Provider.Humana.com/working-with-us/web-based-training.

Chronic and complex conditions

Comprehensive diabetes care

Diabetic retinal examinations

Humana is committed to reducing the incidence of diabetes-induced blindness in 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, PCPs provide or manage services such that members with a history of diabetes will receive at least 1 funduscopic exam every 12 months.

Glycohemoglobin levels

Humana acknowledges tight control of blood glucose levels can delay the onset and slow the progression of many of diabetes' side effects. Glycohemoglobin is 1 laboratory indicator of how well a member's blood sugar is controlled. Consistent with the American Diabetic Association recommendations, PCPs provide or manage 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 diabetic members, better control and maintenance of diabetes is possible. Consistent with the recommendations of the American Diabetes Association, PCPs provide or manage 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

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. PCPs identify 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 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, PCPs provide or manage care for members with CHF by prescribing and monitoring an ace inhibitor, angiotensin II receptor blockers and diuretic, and reviewing the contraindications of the 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 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:

- Member education about the contributing environmental control measures to avoid or eliminate factors that precipitate or exacerbate asthma symptoms
- Introduction of 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
- Education that fosters a partnership among the member, the member's family and clinicians

Hypertension

Humana recognizes PCPs can assist members by checking blood pressure at every opportunity and by counseling members and their families about preventing hypertension. Members 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 Humana MMAI 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 identification of issues related to medications, activities of daily living and pain management are important evaluations for MMAI members. The PCP is expected to assess the member's functional status and current medications, perform a pain assessment, and have a discussion regarding advance 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 must ensure adequate accessibility to healthcare 24 hours a day, 7 days a 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 1 business day when medically necessary.

Routine sick member care—Member must be seen within 3 weeks of the date of the request.

- Well-care and routine visits—Member must be provided an appointment within 5 weeks of making a request.
- Problems or complaints not deemed serious—Member must be provided an appointment within 3 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 7 calendar days of the request.
- Third trimester—Member must be provided an appointment within 3 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 PCMH must:

- Enhance access and continuity: The PCMH must 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 (QI).

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 must 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
- Provision of adequate disability-accessible parking

For members who need interpretation services, the provider or member can call the number on the back of the member ID card or visit 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 to help ensure required ADA compliance.

Member special needs consideration

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

In recognition of these significant member needs, Humana incorporates all principles of multidisciplinary 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 members receive 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.
- An HRA produces a clinically sound profile of the member's health status.
- The HRA provides an overall risk score that, when combined with the predictive model score, is used to direct targeted interventions. The member is encouraged to participate in all aspects of care management and coordination, including the development of an ICP.
- The care coordinator and ICT ensure 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 ensures members receive 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' access to quality, cost-effective care and preventive services.
- Organizational barriers, including lack of interpreter services, wheelchair accessibility issues 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 nonmedical services can cause care barriers.
- Cultural and religious beliefs impact member health beliefs and behaviors, including provider relationships and compliance with 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 members with family planning services without preauthorization. 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 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 guidelines 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 services representative. Preventive guidelines and clinical practice guidelines also are available online at Provider.humana.com/patient-care/guidelines.

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 section of this manual for more information.

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 overuse of medical, surgical, trauma or emergency services
- When documentation of ER 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 talking about the quitting process

Change of provider data

Any change in a provider's name, address, telephone number or change of ownership must be reported immediately to Humana Provider Relations online via 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 nonclinical 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 QIPs, CAHPS, performance measures, annual medical record audit or EQRO indicate unacceptable performance, HFS may impose penalties.

Provider requirements related to community outreach

Providers:

- Can display health plan-specific materials in their own offices
- Cannot, outside of confirming health plan participation, compare benefits or provider networks among health plans, either orally or in writing
- Can announce a new or changing health plan affiliation and give their patients a list of health plans with which they contract
- Cannot make provider affiliation announcements that include marketing content
- Cannot be limited by Humana MMAI from communicating with the member
- Can cosponsor events, such as health fairs, and advertise with the health plan in indirect ways, such as television, radio, posters, flyers and print advertisement
- Cannot 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 assist with enrollment to the health plan
- Can 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 Illinois Medicaid Program Advanced Cloud Technology (IMPACT) program and are in accordance with the IMPACT agency guidelines.

National Provider Identifier

Providers must have an NPI in accordance with Section 1173 (b) of the Social Security Act, as enacted by Section 4707 (a) of the Balanced Budget Act of 1997.

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, 7 days a week via Availity Essentials at www.availity.com. Providers also can manually complete the training by visiting Provider.Humana.com/working-with-us/provider-compliance.
For additional provider training, visit Provider.Humana.com.

Note: Directions for accessing general compliance and fraud, waste and abuse training modules can be found at Humana.com/Fraud. Providers and their office staff can access these online training modules 24 hours a day, 7 days a week.

For LTSS and behavioral health providers, please see the LTSS 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:

- The member's identifying information including name, member ID, date of birth, sex and details of legal guardianship
- A summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs, and current medications
- A description of chief complaint or purpose of visit, the objective diagnosis, and 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 (e.g., 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 member was provided written member rights information including details on advance directives and confirmation member has received the advance directive information

Claims submission protocols and standards

Submitting an electronic claim

Healthcare providers can use Availity Essentials and EDI services as no-cost solutions for submitting claims electronically. To register for Availity Essentials or to learn more about Availity claims solutions, visit www.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 (for fee-for-service claims/non-capitated)
- Encounters: 61102 (capitated)
- Delegated encounter claims: 61105
- Behavioral health claims via Carelon: BHOVO

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

Timely provider payments

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

Providers are required to file their claims/encounters for all services rendered to Demonstration members in a timely manner. 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 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. This includes the fiscal agent making payments to personal assistants under the home- and community-based services (HCBS) waivers for covered services. 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 of submission receipt. Humana pays 99% of all clean covered provider service claims within 90 days of 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 ability to effectively interact with people from different cultures. 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.

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 nonpaternalistic partnerships with communities on behalf of individuals and defined populations.1

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 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. Patients from these cultures may feel uncomfortable questioning doctors' decisions or asking questions.

Additional considerations for healthcare encounters include:

- Communication styles—In some cultures, direct communication is valued, while in others, indirect or nonverbal cues may be more significant. Understanding these nuances helps healthcare providers convey information effectively.
- Beliefs about health and illness—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—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—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—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—Dietary preferences, traditional healing practices and health rituals can impact treatment adherence and the effectiveness of medical interventions.
- Language and health literacy—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—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 nonverbal 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 (LEP)
  - Utilizing professional interpreters to enhance communication

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

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 one-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.

Key considerations include:
- 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 can 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 nonsecure website and member materials
- TTY 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 ICPs that include consideration of special and unique member needs in accordance with the 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 those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C and the Memorandum of Understanding 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 ICP
      - 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 from 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 require the disclosure and delivery of such information to allow the member to make an informed choice
    - To encourage caregiver or family member participation in treatment discussions and decisions
    - To explain and encourage advance directives, if the participant so desires, in accordance with 42 C.F.R. §§489.100 and 489.102
    - To provide reasonable advance notice in writing of any transfer to another treatment setting and the justification for the transfer
- The right to be afforded the opportunity to file an appeal if services are denied that the member thinks are medically indicated, and to be able to 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 nonmedical care from a team that meets the member's needs in a manner that is sensitive to the member'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 (balance 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 and 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 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 try to reduce fraud, waste and abuse (FWA) in the Medicare and Medicaid programs. Healthcare FWA can involve providers, pharmacists, members and medical equipment companies. Success in combating healthcare FWA is measured by convictions and by effective deterrent efforts.

Reporting FWA

Anyone who suspects or detects an FWA violation is required to report it either to Humana or within their organization, which then must report it to Humana through 1 of the following methods:

Phone

Special Investigations Unit Hotline: **800-614-4126**
- Monday – 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 Ethics Every Day or Online Reporting

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—e.g., dates and people, systems, and types of information involved—to allow Humana to review the situation and respond appropriately.

Confidentiality: Processes are in place to maintain confidentiality of reports, and 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 FWA Training at https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN3995723-MLNPartsCD/FWA/story.html and Medicare Parts C and D General Compliance Training document at https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/Medicare_Parts_C_and_D_General_Compliance_and_FWA_WBT_2016.pdf published by CMS.

Note: The concepts in the CMS document apply to all Humana lines of business. More information is available on Humana's website for addressing fraud, waste and abuse. Please refer to the Illinois Medicare-Medicaid provider training materials website for more information.

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:

- **Abuse:** nonaccidental infliction of physical and/or emotional harm
- **Physical abuse:** causing the infliction of physical pain or injury
- **Sexual abuse:** unwanted touching or fondling, sexual threats, sexually inappropriate remarks, or any sexual activity with a person who is unable to understand or unwilling to consent to sexual activity or who has been threatened or physically forced to engage in sexual activity
- **Psychological abuse:** includes name calling, intimidation, yelling and swearing; may also include ridicule, coercion and threats
- **Emotional abuse:** verbal assaults and 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 that results or could reasonably be expected to result in serious physical or psychological/emotional injury or substantial risk of death (This includes self-neglect and passive neglect.)
- **Exploitation:** illegal use of assets or resources of an adult with disabilities; including misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, or by fraud, deception, extortion, or in any manner contrary to law

In most states, including Illinois, 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 annual required health, safety and welfare education compliance 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 ICP 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, most cost-effective and most 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, 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 beneficiary 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, SNFs, home health and personal care organizations in our network.

Provider services 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.

Provider services 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; preauthorization and referral may be required

Adult day services

Covered services: Adult day service provides direct care and supervision of adults ages 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: This service offers provision or arrangement for transportation, with at least 1 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 2 one-way trips of transportation will be provided per participant in a 24-hour period, and this does not include trips to a provider, trips 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: The automated medication 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. It is intended 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: Behavioral services includes therapy services designed to assist members with brain injuries manage behavioral 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: This service includes those physical adaptations to the home, required by the ICP, 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.

Adaptations or improvements to the home that are of general utility and are not of direct remedial benefit to the member are excluded.

Vehicle modifications (e.g., 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 of self-help, socialization and adaptive skills which takes place in a nonresidential 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 must be coordinated with any physical, occupational or speech therapies listed in the ICP. 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: This service includes prepared food brought to the member's residence that may consist of a heated luncheon 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: This includes service provided by an individual who 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 nonmedical support by supervised and trained homemakers. Homemakers are trained to assist individuals with activities of daily living, including personal care, laundry, shopping and cleaning. The purpose of providing homemaker service is to maintain, strengthen and safeguard the functioning of members in their own homes, also known as in-home care, in accordance with the authorized ICP. 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: This service includes 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 provider'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 provider'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 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 completion of 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: A personal emergency response system (PERS) is an electronic device that enables individuals to remain safe in their homes 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 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 and adult day care and are provided to a member to provide for 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 to be provided in the member's home or in a children's community-based healthcare center model, licensed by the Illinois Department of Public Health (IDPH).

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

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 nondurable 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: This service includes 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 member's ID card.

Care coordination and service authorization

LTSS service authorizations are created by the LTSS UM team. Preauthorization requests for PERS must be submitted through the LTSS team by either contacting the care coordinator (CC) or 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 stateprovided 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 preauthorization additions or changes must go through the CC and be based on member assessment of needs. Providers can email Humana LTSS CCs at HumLTSStransitions@humana.com to request LTSS services on behalf of a 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.

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 be recredentialed or 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 at https://hfs.illinois.gov/impact.html.
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 will 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 nondiscriminatory 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.

Humana's Non-Discrimination, Cultural Competency, Language Proficiency and ADA plan is available online or via a paper copy by calling Humana Customer Service at 800-4HUMANA (800-448-6262) or by calling 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 meets the diverse needs of patients and 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 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 (OIG) list since 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 of 1996 (HIPAA). Member files will be kept confidential at all times.

Providers should take 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 Humana-identified, compliance-based training programs. This includes agreement and assurance all participating providers and staff members are trained on the identified compliance material. This training includes:

- 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: affirmative action, diversity and the cultural competency plan section of this manual
- Humana's health, safety and welfare training: health, safety and welfare section of this manual
- Humana's fraud, waste and abuse training: introduction to fraud, waste and abuse section of this manual

Additional information on these topics is included in Humana's required annual compliance training. For help accessing this required training, call Humana MMAI Provider Services at 800-787-3311, Monday – Friday, 7 a.m. – 7 p.m., Central time, or visit www.availity.com or Provider.Humana.com/working-with-us/provider-compliance.

Emergency service responsibilities

Humana has an emergency management plan that specifies what actions we conduct to ensure the ongoing provision of covered services in a natural disaster or man-made emergency, including localized acts of nature, accidents, and technological and/or attack-related emergencies.

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

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

This does not mean the provider must obtain verification before providing emergency services and care.

Weather-related and emergency-related closings

Emergencies such as severe weather, fires or power failures can disrupt operations. In such instances, it is important to keep Humana informed of your status, especially if you have an active authorization for a member. Resources can be found at the Illinois Emergency Management Agency website at https://iemaohs.illinois.gov.

Standards of conduct

Stakeholder expectations

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 ICP and makes appropriate care plan information available for LTSS provider use.

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 takes 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 of an adverse event, such as member death, when a member decides to leave the facility against medical advice. Cases of neglect, abuse, exploitation or fraud 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:

- Decline in member's health status due to medication management
- Significant worsening of activities of daily living
- 2 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 (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:

- 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 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:

- For children younger than 18, call 800-25ABUSE (800-252-2873). If you use a TTY, call 800-358-5117.
  - For more information, visit the Illinois Department of Child and Family Services website at http://www.illinois.gov/dcfs/safekids/reporting/Pages/index.aspx.
- For members with disabilities age 18 and older and seniors living in the community, or if the abuse, neglect or exploitation (ANE) occurs in the community to a member living in a licensed facility, call the Illinois Department on Aging, Adult Protective Services (APS) at 866-800-1409. If you use a TTY, call 800-206-1327.
  - For more information, visit the Illinois APS website.
- For members in nursing facilities, call IDPH's nursing home complaint hotline at 800-252-4343.
  - For more information, visit http://www.dph.illinois.gov/topics-services/health-care-regulation/complaints.
- For members 18–59 receiving mental health or developmental disability services in DHS-operated, -licensed, -certified or -funded programs, call DHS, OIG at 800-368-1463 (voice and TTY).
  - For more information, visit http://www.dhs.state.il.us/page.aspx?item=32675.
- For members in supportive living facilities (SLFs), call HFS' SLF complaint hotline at 800-226-0768.
- To reach the Illinois Domestic Violence Victim Services hotline, call 877-TO-END DV or 877-863-6338, or visit www.dhs.state.il.us/page.aspx?item=30275.
- To report fraud to the OIG General Medicaid/Welfare, call 844-ILFRAUD (844-453-7283), or visit the Illinois report fraud website.
- For the Illinois Helpline for Opioids and Other Substances, call 833-234-6343 or visit www.Helplineil.org.
- To reach the 988 Suicide & Crisis Lifeline, call 988, or visit https://988lifeline.org/.
- To reach the National Human Trafficking Hotline, call 888-373-7888 or visit 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 during and after the transition period.

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 Service Employees International Union 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, housekeepqing, 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:
  - Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
  - Match the level of safety, efficacy, and cost-efficient treatment and services available statewide
  - Consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
  - 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 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 can complete a 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 beneficiaries. 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.

To verify enrollment, providers can sign 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.

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

Indications of proper provider 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 providers with enrollment, including change of address, change of ownership and reenrollment issues, via the HFS website.

Guidelines on how providers should enroll with Illinois MMAI can be found in Chapter 100 — General Policy and Procedures: Topic 101, Provider Enrollment, of the HFS Handbook for Providers of Medical Services of the HFS Provider Handbook.

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 necessitating a new federal tax identification number terminates the participation of the enrolled provider in IMPACT. Participation and approval

in IMPACT is not transferable and providers must reenroll. 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 and specialties

Although categories of service (COS) are 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 an 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 nontraditional 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 1 of 3 ways:

- For the most efficient application processing and the fastest receipt of NPIs, use the web-based application process. Simply sign in to 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 organization (EFIO) submit application data on their behalf (e.g., 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:** Call **800-465-3203** or, if you use a TTY, call **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 www.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 and TIN for the health facility or health professional that provided the treatment or service. Always ensure 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 2 of the most common reasons for claim denials. If you are an atypical provider (e.g., 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 Illinois Association of Medicaid Health Plans (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 5 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/COS/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 in Health Care Provider Taxonomy at https://www.nucc.org/images/stories/PDF/taxonomy_24_0.pdf (opens a PDF).

The taxonomy code used must match a corresponding COS, procedure code (PC) and/or place of service (POS). A crosswalk of taxonomies with COS, PC and POS is available at https://hfs.illinois.gov/medicalproviders/cc/encountermanual/appendixaencounterclaimscrosswalks.html.

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 at Provider.humana.com/medicaid/illinois-medicaid/compliance-training-materials.

Atypical providers (e.g., waiver services providers) should submit claims using their TIN and HFS Medicaid number. Do not include an NPI. Please reference the IAMHP Comprehensive Billing Manual.

The following HFS provider types are considered HCBS providers that can bill to Humana:

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)

To file a claim for Humana-approved services for 1 of the 4 HCBS waivers described above, waiver providers are required to register as waiver providers with IMPACT. Many HCBS providers are considered atypical by HFS' IMPACT system. HFS' IMPACT definition of an atypical provider is a provider who delivers 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 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

Humana accepts 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. 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 EDI services as no-cost solutions for submitting claims electronically.

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

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

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 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 of the final determination of the primary payer and in accordance with the Managed Care Manual.

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 nonparticipating providers

Humana considers a claim resubmission within 365 days of the primary payer's RA or EOB.

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 ID number
- Service or admission date
- Treatment, service or procedure location
- Request-supporting documentation
- A copy of the claim
- A copy of the RA 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 covered by Medicare through fee-for-service Medicare or an MA 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 noncovered 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 EOB or the RA for services rendered to members who have insurance in addition to Humana. The primary carrier's EOB or RA 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 RA. This information is essential for Humana to coordinate benefits.

If a service is a noncovered 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 Humana MMAI Provider Services at **800-787-3311** and selecting the Claims option or via www.availity.com.

Preauthorization 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 authorization 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 providers 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 who 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 HCBS under the 1915(c) waiver. CMS also published expectations regarding person-centered plans of care and provided 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 HCBS 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 noncompliant 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 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 2 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 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 Services 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 **800-397-1630**, Monday – Friday 8 a.m. – 8 p.m., Eastern time. Clinical staff can be reached there 24 hours a day, 7 days a week for preauthorization 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 notifies 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 PSA 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 authorization, 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 at https://providerportal.carelonbehavioralhealth.com/index.html%23/login, 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 PSA 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, www.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, you can also access eServices and EDI through the website.

Electronic media

To streamline network providers' business interactions with Carelon, we offer 3 provider tools— eServices, IVR and EDI.

eServices

Through eServices, Carelon's secure web portal, all provider transactions are supported, which saves time, postage expense, billing fees and paper waste. Access to eServices is free to Humana-contracted Carelon network providers and can be found at www.carelonbehavioralhealth.com, 24 hours a day, 7 days a week.

Some features include:

- Automatic population of many fields to minimize errors and improve claim approval rates on first submission
- Claim status available within 2 hours of electronic submission
- Stored, printable confirmation and transaction history for future reference for all transactions

Since 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 controls which users can access each eServices feature.
Register for eServices at www.carelonbehavioralhealth.com/providers/resources/provider-portals.

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

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 and NPI, as well as the 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: www.carelonbehavioralhealth.com/content/dam/digital/carelon/cbh-assets/documents/global/guides/837-health-care-claim-companion-guide.pdf (opens a PDF).

Carelon accepts standard HIPAA 837 professional and institutional healthcare claim transactions and provides 835 RA response transactions.
To set up an EDI connection, view the companion guide located on Carelon's provider portal at www.carelonbehavioralhealth.com, 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 preauthorization 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 LOCC 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 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 PHI.

Access standards

Humana members may access behavioral health services 24 hours a day, 7 days a week by calling Humana's Member Services line at **855-371-9234**. The main Humana line includes an option for connecting directly to Carelon Health member services for emergencies or preauthorization 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 7 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 of 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	Provide 24-hour, on-call services for all members in treatment. Ensure 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, 7 days a week. Outpatient facilities and providers are expected to provide these services during operating hours. After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering provider, agency-affiliated staff, crisis team or hospital.
Outpatient services	Outpatient providers should have services available Monday – Friday 9 a.m. – 5 p.m., at a minimum; evening and/or weekend hours also should be available at least 2 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 members have access to medical interpreters, sign language interpreters and TTY services to facilitate communication when necessary and ensure 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 ADA-compliant. 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 1 business day informing the member and provider that the wait time access standard was not met.

Provider credentialing and recredentialing

All Illinois providers wanting 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 providers 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 the provider education of compliance-based materials section of this manual.

Member billing prohibitions

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 as 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 1 evaluation visit for Humana members without authorization on completion and return of the signed SCA. After the expiration of existing authorization, 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 www.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 ensure appropriate referrals to available appointments. The bulleted list 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 appointment 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 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 provided to members 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 preauthorization 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
- 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 useful for the research project but not medically necessary for the member's care.
- Preauthorization 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 members are active and informed participants in the planning and treatment phases of their behavioral care. We believe 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.

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 the grievances and appeals section 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 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 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 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.

Nondiscrimination 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

- Preexisting 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 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. Due to 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:

- Submitting and seeking payment of claims
- Seeking authorization for extended treatment
- Implementing QI initiatives, including aligning information regarding member diagnosis, treatment and condition to ensure compliance with contractual obligations
- Reviewing member information in the context of management audits, financial audits or program evaluations
- Reviewing charts to monitor the provision of clinical services and ensure 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 provider should ask the member to sign a statement authorizing the sharing of clinical status information with the PCP and for the PCP to respond with additional member information.
A sample form is available at www.carelonbehavioralhealth.com/providers (see the Provider Tools webpage at www.carelonbehavioralhealth.com/providers/resources/provider-toolkit), 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. Also, the provider should advise the member if the member refuses authorization for release of information for payment purposes, the member 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 member ID card does not guarantee member eligibility. Providers are strongly encouraged to check member eligibility frequently.

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 at www.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

You can search multiple member ID numbers in a single request.

Call Carelon provider IVR at **855-481-7044** 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 and NPI and 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 when authorizing services.

In accordance with the Privacy Act, Carelon requires the provider be prepared to provide specific identifying information (e.g., NPI and 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 continually monitors and improves 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 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 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 providers 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 supporting recovery. Member education should be person-centered and recovery-focused and should promote compliance with treatment directives and encourage self-directed care.

- Members interested in participation with Carelon's Member Advisory Council should contact Member Services at **855-371-9234**.

Quality monitoring

Carelon monitors provider activity and uses 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:

- Site visits
- Treatment record reviews
- Satisfaction surveys
- Internal monitoring of timeliness and accuracy of claims payment
- Provider compliance with performance standards including:
  - 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 QI 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 uses 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 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 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 3-4 Treatment records documentation requirements

Documentation	Is there documentation the member received a copy of their rights? Are medication allergies and adverse reactions prominently noted in the record? If the member has no known allergies or adverse reactions, is this noted? Is past medical history easily identified? If no significant medical history, is this noted? Is there documentation 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 1 release of information, authorization or consent was obtained to speak with at least 1 other outpatient (OP) mental health or OP substance use treatment provider if required for specially protected information? Is there evidence the OP treatment provider contacted another OP behavioral healthcare provider after initial assessment/evaluations for collaboration? Is there evidence that the OP treatment provider had ongoing contact with the other behavioral healthcare 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)? Is there evidence 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? Is there documentation if the member refuses due to active symptoms? Is there documentation if the member refuses due to expressed concern over privacy? Is there documentation if the member's guardian does not want information shared with the PCP? Is there documentation if the member will not state a reason? (Examples may include legal issues, member does not want medical records to be released to another party, etc.) Is there evidence the OP treatment provider contacted and collaborated after initial assessment/evaluation? Is there evidence the OP treatment provider had ongoing contact with the 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? Is there evidence of bidirectional communication?
Evaluation of treating provider communication (Behavioral health: PCP)	Is there evidence in the chart the behavioral healthcare provider communicated with the OP behavioral healthcare provider 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+) Adult suicide risk CPG: Was a standardized suicide risk screening or assessment tool used? (18+) Adult suicide risk CPG: If yes to above, what tool was used? 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+) Adult psychiatric evaluation CPG: Is there documentation of a substance use assessment? (18+) Adult psychiatric evaluation CPG: Is there documentation of a cultural and/or linguistic assessment? (18+) Adult psychiatric evaluation CPG: Is there documentation of a medical assessment? (18+) ADHD CPG: Is there documentation the member meets the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria, including documentation of symptoms and impairment in more than 1 major setting (e.g., social, academic or occupational)? 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 International Classification of Diseases (ICD) diagnosis consistent with presenting problems, history, mental status exam and treatment plan? Does the treatment plan include objective and measurable goals? Does the treatment plan include short-term time frames for goal/objective attainment or problem resolution? Is utilization appropriate for diagnosis and the treatment plan? Are progress notes goal-oriented and focused on treatment objectives?

Telehealth member safety (applicable to all charts if telehealth modality)	Did the behavioral healthcare provider document the member's written or oral consent to receive services via telehealth? Did the provider document if the session was conducted via video or phone? Did the provider document the member's physical location at beginning of session? If there was a technical difficulty did the provider document alternate communication and how the 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 including 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
- Identification of members needing communication assistance in the delivery of healthcare services

Advance directives

Carelon practices an integrated approach to advance directives between behavioral and physical healthcare providers.

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 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 regarding significant changes in the member's condition, diagnosis and/or level of care.

State law allows for 3 types of advance directives: healthcare power of attorney, living will and mental health treatment preference declaration. Providers should ensure members are informed of these rights.

You can download forms and documentation regarding advance directives from the IDPH website at https://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives.

Performance standards and measures

To ensure a consistent level of care and framework for evaluating the effectiveness of care within the provider network, 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:

- 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 and consider these guidelines whenever they 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 provider experience with any other guidelines. To provide feedback or request paper copies of the Carelon practice guidelines, email Provider Relations 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 providers document communication attempts (with member consent) to communicate with the member's PCP. Providers are expected to submit quarterly (or 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

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

- Notice of commencement of OP treatment within 4 visits or 2 weeks, whichever occurs first
- Notice of initiation and any subsequent modification of psychotropic medications
- Notice of treatment termination within 2 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 if it includes:

- 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 3 business days of the request should include:

- 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

OP providers' compliance with communication standards is monitored through requests for preauthorization 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 OP 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 healthcare providers

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

Routine OP 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 of 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 healthcare providers and assist with referrals to ensure members released from inpatient levels of care are scheduled for follow-up appointments within 7 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 of the missed appointment.

Carelon's care managers and aftercare coordinators assist by sending member reminders, working to remove barriers that can 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 members have the support needed to maintain community placement and prevent unnecessary readmissions.

Reportable incidents and events

Humana Gold Plus Integrated and Carelon require all providers to report all potential quality of care and critical incidents involving a member on the day of the incident to Carelon by calling 855-371-9234. A potential quality of care (PQOC) concern is defined as 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.

Member safety is paramount. Please call 911, local authorities or emergency medical services if a member's health and safety is at immediate risk. The report should include:

- 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
- 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 of physically aggressive behavior, particularly if resulting in harm or injury to the provider
- Property damage by member of $50 or more to provider property
- Suicide attempt by member and/or suicide ideation/threat by member
- Suspected alcohol or substance misuse by member
- Seclusion of a member
- 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
- Sexual harassment by provider, sexual harassment by member, and/or sexually problematic behavior of the 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.
  - 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, 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 an 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, the IDOA Elder Abuse and Neglect program (mistreatment of members 60 years of age or older who live in a community) also includes reporting physical abuse, sexual abuse, emotional abuse, confinement, passive neglect, willful deprivation and financial exploitation of the elderly. Also, the Illinois Department of Healthcare and Family Services Incident Reporting for Supportive Living Facilities also includes reporting 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, and evacuation of residents for any reason.

Please refer to the table that follows for more details about reporting incidents and events to Carelon.

Reporting incidents and events to Carelon

Objective	Details
Reporting	Carelon's Clinical department is available 24 hours a day. 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 clinician by phone. Providers are required to complete the PQOC form. The form can be sent to the member safety team via fax at 855-677-7672 or via email at CorporatePQOC@carelon.com. Incident and event reports should not be emailed unless the provider uses a secure messaging system.
Prepare to provide the following:	All relevant information related to the nature of the incident The parties involved (names and telephone numbers) 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, psychosocial, 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 result in poor health status and ineffectual expenditures.

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

The provider's participation is key and includes:

- 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
- Promotion of HEDIS and NCQA quality measures
- Provision of all medical record documentation and information as requested to support Humana's fulfillment of state and federal regulatory and accreditation obligations (e.g., HEDIS)

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

- Assuring 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
- Ensuring 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
- Providing coordination of care for members who are homebound or have significant mobility limitations to ensure access to care through home visits by providers
- Tracking and documenting appointments, clinical treatment plans and member care received from specialists, other healthcare providers or agencies to ensure continuity of care
- Obtaining preauthorization for and notifying Humana of any out-of-network services when an in-network provider of the specialty in question is not available in the geographical area
- Working with Humana's care coordination team to arrange for a member to receive a second opinion from a qualified in-network provider or arranging for the member to obtain one outside the network if a qualified in-network provider is unavailable

Provider creation and participation in individualized care plans

The ICP 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 is expected as they are an integral part of the member's 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 member and/or the member's authorized caregiver
- The member's healthcare providers
- Humana's care managers and coordinators
- Social workers and community social-service providers
- Humana's and/or the member's behavioral healthcare professionals
- Humana's community health educators and resource-directory specialists
- The provider's goals via the Humana Cares team of nurses, social workers, pharmacy specialists and behavioral healthcare specialists
- Member education and enhancement of direct patient-provider 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 responding 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

When working with Demonstration members with a mental health diagnosis, providers should:

- 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.

When understanding chronic conditions prevalent within the Demonstration population, providers should be aware:

- 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 hospitalization and ER visits. Evidence indicates preventive care and frequent/consistent care of chronic conditions lowers the advent of major conditions and decreases use of ER visits and readmissions.
- Humana's Clinical Practice Guidelines are available online to all providers and adopt relevant, evidence-based medical and behavioral health guidelines 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 or 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 who meet the member's cultural and linguistic needs.
  - Review the list of recommended behavioral healthcare providers with the member.
  - Encourage the member to select a recommended behavioral healthcare provider; if the member is 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 healthcare provider.
  - Obtain member permission for the exchange of relevant health information between new behavioral healthcare

provider, PCP and other providers.

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 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 UM techniques and in Carelon's standards and protocols. All Carelon employees with responsibility for making UM decisions have been made aware that:

- All behavioral 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 (ASAM) 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 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 NCDs and LCDs
- Change Healthcare's InterQual® Behavioral Health Criteria
- ASAM Criteria
  - ASAM Criteria focuses on substance use treatment.
  - Unless custom criteria exist or for substance use lab testing, 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 3-5 UM terms and definitions

Adverse benefit determination	(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 time frames for the standard resolution of grievances and appeals; (vi) for a resident of a rural area with only 1 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: Carelon's denial, in whole or in part, of payment of a service or failure to provide covered services in a timely manner in accordance with the waiting time standards Carelon's denial or limited authorization of a requested service, including the determination that a requested service is not a covered service Carelon's reduction, suspension or termination of a previous authorization for a service 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 denials based on: Failure to follow preauthorization procedures Failure to follow referral rules Failure to file a timely claim Carelon's failure to act within the time frames for making authorization decisions Carelon's failure to act within the time frames for making appeal decisions
Nonurgent 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 nonurgent concurrent decision may authorize or modify requested treatment over a period of time or a number of days or treatment or deny requested treatment in a nonacute treatment setting.
Nonurgent preservice review and decision	Any case or service that must be approved before the member obtains care or services: A nonurgent preservice decision may authorize or modify requested treatment over a period of time or number of days or treatments or deny requested treatment in nonacute 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 preservice review.
Urgent care request and decision	Any request for care or treatment for which application of the normal time period for a nonurgent 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 provider 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 OP 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 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 member ID card does not guarantee the member is eligible for benefits. Providers are strongly encouraged to check Carelon's eServices or call Carelon Provider Services at **855-481-7044**.

Emergency services

Definition

Emergency services are those provider and OP 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 preauthorization. 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 were not previously 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, the member should call 911 or go directly to the nearest ER. The member does 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 a day, 7 days a week to answer questions, assess 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 Illinois Medicaid Customer Care at **800-787-3311 (TTY: 711),** Monday – Friday, 7 a.m. – 7 p.m., Central time.

Emergency screening and evaluation

Members must be screened for an emergency medical condition by a qualified behavioral health professional from the hospital ER, 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 complete, the facility or program provider should call Carelon to complete a clinical review if admission to a level of care that requires preauthorization is needed. The facility/program provider 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 outofnetwork 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, 7 days a week to receive crisis calls from providers for authorization of inpatient admission.

Disagreement between provider adviser and attending provider

For acute services, in the event that Carelon's provider adviser and the emergency service provider do not agree on the service the member requires, the emergency service provider'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 covered under the member's program of medical assistance or medical benefits.

Authorization requirements

For a complete listing of covered services and authorization requirements, please refer to the preauthorization section of this manual.

Outpatient treatment

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

The care manager assists you in optimizing each member's benefits. While traditional OP services do not require preauthorization, our care managers work with treating providers to ensure members get the care they need. Carelon conducts outlier management of OP 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 call Carelon to continue the request for authorization.

While Carelon prefers providers 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 3-6 Providers receive an email message alerting them 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 grievances and appeals section of this manual. All forms can be found at www.carelonbehavioralhealth.com under Provider.

Inpatient services

All inpatient services, including inpatient electroconvulsive treatment (ECT), require telephonic preauthorization 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. 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 requesting facility provider will need 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-V diagnosis: All 5 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 utilization review clinician with the following required information:

- Member's current diagnosis and treatment plan, including provider'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 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 OP services rendered when necessary. To initiate a post-service review, call Carelon. If the treatment rendered meets criteria for a post-service review, the utilization review 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 sections 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 provider 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 or provider includes the specific reason for the denial decision; the member's presenting condition, diagnosis and treatment interventions; the reasons 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

options 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 actions 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 in Table 3-6. .

If the clinical information available does not support the requested level of care, the utilization review 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 utilization review clinician and the requestor, the utilization review clinician consults with a Carelon provider (for OP services only). All denial decisions are made by a Carelon provider (for OP services only). The utilization review clinician and/or Carelon provider 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 TTY capability in established prevalent languages (Babel Card).

Termination of outpatient care

Carelon requires that all OP 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 OP 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 preauthorization 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 member or member's provider disagrees with a utilization review decision issued by Carelon, the member, the member's 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, the case is reviewed based on the information available and makes a determination within 1 business day. If members, member representatives or providers are not satisfied with the outcome of reconsideration, they may file an appeal.

Table 3-6 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 nonurgent 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 3 calendar days
Continued authorization for nonurgent behavioral health services	Nonurgent/ standard	Within 14 calendar days	Within 14 calendar days	Within 14 calendar days
Post-service				
Authorization for behavioral health services already rendered	Nonurgent/ standard	Within 30 calendar days	Within 30 calendar days	Within 30 calendar days

Provider appeals

Provider appeals and grievances procedures

You have the right to file a medical necessity appeal with Humana.
You have the right to file with Carelon:

- Contractual appeals
- Administrative appeals (e.g., claims appeals)
- Provider grievances

How to submit a provider appeal

Claim appeals

You can submit provider disputes by calling 855-481-7044 Monday – Friday, 7 a.m. – 5 p.m., Central time.

Email

Provider claims disputes submitted in writing must be emailed to WoburnClaimAppeals@carelon.com.

Fax

You can submit provider disputes via fax to 305-722-3013.

Provider Portal

You can submit provider disputes online via the Carelon provider portal at www.carelonbehavioralhealth.com.

Select “tools” and enter the health plan name, then select “Claims.”

Writing

Please refer to the Humana claim-payment inquiry resolution guide for more information. Be prepared to provide the following information:

- The member’s name and Humana member ID number
- The provider’s name and Carelon provider ID number
- The code 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

Submit written provider disputes via mail to:
Carelon Health Options
P.O. Box 1856
Appeals Department
Hicksville, NY 11802-1856

Member grievances, appeals and fair hearing requests

Members have the right to file a grievance or appeal. They also have the right to request a fair hearing once they exhaust their appeal rights.

Carelon strongly encourages providers use electronic submission, either through EDI or eServices, to achieve the highest success rate of first-submission claims.

General claim policies

Carelon requires providers adhere to the following policies with regard to claims.

Clean claims

A clean claim, as discussed in this provider manual, the PSA 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 redistribution 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 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 of 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 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 will 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, Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS) and ICD codes. Providers should refer to the Carelon provider portal at www.carelonbehavioralhealth.com 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 3-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 provider or be 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.

Table 3-7 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 is 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 must receive claims for covered services within the following designated filing limits:

- Within 60 days of the dates of service on OP 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 Table 3-8 of this manual.

Coordination of benefits (COB)

In accordance with the National Association of Insurance Commissioners (NAIC) regulations, Carelon coordinates benefits for behavioral health and substance use claims when it is determined a person is covered by more than 1 health plan, including Medicare:

- When it is determined that Carelon is the secondary payer, claims must be submitted with a copy of the primary insurance's EOB report and received by Carelon within 60 days of the date on the EOB.

Carelon 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 who may be experiencing claims payment issues, Carelon runs quarterly reports identifying those providers who 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 with 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 along with 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 www.carelonbehavioralhealth.com/providers
Carelon's portal
eServices User Manual
EDI Transactions – 837 Companion Guide (behavioral health)
EDI Transactions – 835 Companion Guide

Email contacts

- Provider.relations.IL@carelon.com
- e-support.services@beaconhealthoptions.com

Telephone contact info

Providers should have your practice or organization's TIN, the member's ID number and date of birth, and the date of service.

Claims hotline/IVR: **855-481-7044**, Monday – 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 1 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, 2 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 1 minute and contain few, if any, errors.

Interactive Voice Recognition

IVR provides telephone access for member eligibility, claim status and authorization status 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.

Transaction	Access			When applicable	Carelon receipt time frame	Other information
	EDI	eServices	Phone			
Member eligibility verification	Y	Y	Y	• Completing any claim transaction • 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 1 of the following conditions is met: • Provider is eligible for retroactive reimbursement • Member was retroactively enrolled in the health plan • Services were retroactively authorized • 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. All other requests result in a claim denial on a future EOB: • A claim submitted beyond the filing limit that does not meet the above criteria that includes retroactive updates to member eligibility, provider network status, or fee schedule, may be submitted as a reconsideration request. • 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 of 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: • Underpayment (positive request) • Overpayment (negative request)	Positive Carelon request must be received within 180 days of original payment date. No filing limit for negative requests.	Do not send a refund check to Carelon. A rec ID is required to indicate that the claim is an adjustment. 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. If an incorrect adjustment appears on an EOB, another adjustment request may be submitted based on the previous incorrect adjustment. 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 of receipt by Carelon.
View/print RA	N	Y	N	Available 24/7 for all claim transactions submitted by Carelon	N/A	Printable RA is posted within 48 hours of 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 UB04 claim form. No other forms are accepted.

Paper claims must be submitted using the most current form version as designated by CMS and 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:

Paper Claims
Carelon Health Options Attention: Claims Department
P.O. Box 1866
Hicksville, NY 11802-1870

Electronic Claims

Claims may be submitted directly to Carelon via an 837 file or via the provider portal (registration required). Carelon Payer ID: 43324

Carelon does not accept faxed claims.

Paper resubmission

- See Table 3-8 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 lines may be resubmitted regardless of the number of claim lines; Carelon does not require 1 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 of 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 of 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.

- **Provider name:** Enter the name of the provider who provided the service.
- **Provider ID number:** Enter the ID number of the provider who provided the service.
- **Member name:** Enter the member's name and ID number.

- **Contact person:** Enter the name of the person whom Carelon should contact if there are any questions regarding this request.
- **Telephone number:** Enter the telephone number of the contact person.
- **Reason for waiver:** Place an "X" on all lines that describe why the waiver is requested.
- **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."
- **Date:** Indicate the date the form was signed.

Paper request for adjustment or void

Before submitting paper claims, please review the electronic claims section of this provider manual.

- See Table 3-8 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 in the completion of the adjustment/void request form section of this provider manual.
- 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.

- **Provider name:** Enter the name of the provider to whom the payment was made.
- **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.
- **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.
- **Member identification number:** Enter the 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.
- **Carelon record ID number:** Enter the record ID number as listed on the EOB.
- **Carelon paid date:** Enter the date the check was cut as listed on the EOB.
- **Check appropriate line:** Place an "X" on the line that best describes the type of adjustment/void being requested.
- **Check all that apply:** Place an "X" on the lines that best describe the reasons for requesting the adjustment/void. If "Other" is marked, describe the reason for the request.
- **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."
- **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:

- 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 website for addressing fraud, waste and abuse

Additional information on these topics is included in Humana's required annual compliance training. Please visit www.carelonbehavioralhealth.com/providers and select "Tools" for help in understanding how to access this required training.

Authorization guidelines (outpatient)

The following outpatient benefits or services have no authorization requirement:

- Case consultation
- Crisis intervention
- Family and marital therapy
- Group therapy
- Individual psychotherapy
- Injection administration
- Medication administration
- Medication management (E/M)
- Mental health risk assessment
- Mental health/SA assessment
- Prenatal care at-risk assessment
- Psychiatric diagnostic evaluation
- Psychiatric diagnostic interview with medical services
- Treatment plan development

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 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 and includes any oral or written expression of member dissatisfaction submitted to Humana or a state agency. Possible complaint subjects include:

- 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—the contract between U.S. Department of Health and Human Services' CMS, in partnership with the Illinois 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 (CHDs)—CHDs are organizations administered by the state health department to promote public health and 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 (SSA) on behalf of the state, pursuant to federal and state laws.
Emergency medical condition—a level of health manifested by symptoms, including pain or other signs of illness, so severe that a prudent layperson with average health and medical knowledge could reasonably expect 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 provider, 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—Humana-covered treatments 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 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: 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 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: A health plan 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, piece of equipment or individual that meets formal state, county and local requirements

Mandates—applicable state and federal laws and regulations, including:

- 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 HFS
- 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 HFS 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

Noncovered 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 provider (or network provider)—a contracted healthcare provider who is under a currently valid provider agreement to participate in Humana's MA and/or Medicaid networks serving Demonstration members

Participating specialist—a healthcare provider 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, providers and, when appropriate, the patient's family: Care is facilitated by registries, information technology, health information exchanges and other means to ensure 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 LTSS member's income which must be paid as their share of the LTSS services expense

Preauthorization—Humana approval of specific services before they are rendered

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-contracted provider 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 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 primary care services be furnished by providers through home visits.

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

Provider contract—an agreement between Humana and a provider

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 consistent with current professional knowledge

Quality improvement (QI)—the process of monitoring and ensuring available, accessible, timely, medically necessary member healthcare and need-appropriate services are provided in sufficient and acceptable quantity and quality and within established excellence standards

Quality improvement program (QIP)—the process of monitoring and evaluating initiatives for improvement ensuring delivery of appropriate, timely, accessible, available and medically necessary healthcare

Sick care—nonurgent health 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 family planning, routine follow-up for previously treated conditions or illnesses, adult physicals, or any routine visit for treatment other than for an illness

Reference

1. Murray-García J, Tervalon M. The concept of cultural humility. Health Aff (Millwood). 2014 Jul;33(7):1303. doi: 10.1377/hlthaff.2014.0564. PMID: 25006160.