

Humana®



2026

**Humana Dual Fully
Integrated (HMO D-SNP)**

2026 Provider Manual

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Welcome

Thank you for your participation with the Humana Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP). A FIDE-SNP is a type of health plan that covers both Medicaid and Medicare benefits.

It is jointly administered by the Centers for Medicare & Medicaid Services (CMS) and the Illinois Department of Healthcare and Family Services (HFS).

On behalf of everyone at Humana, we look forward to a lasting partnership with you and your team.

About this manual

This manual applies to those who provide services to our Humana members. Throughout the manual, all instances of “us,” “we” or “our” refers to Humana, and all references to “you” or “your” refers to you, the provider contracted with us.

All acronyms used within this provider manual are defined in the **Acronyms section** of this provider manual.

Color coding and font variations are used to denote different information throughout this provider manual as follows:

- **Internal references** to other parts of this provider manual are denoted in bold eggplant font and are linked to the relevant section of the manual.
- **Contact information** is denoted in bold teal font and detailed information is available at the beginning of the respective chapter.
- **Hyperlinks** to external resources are denoted in bold green font.

This manual furnishes you and your office staff with important information concerning Humana’s policies and procedures, claim submission and adjudication requirements, and other guidelines used to administer our health plans. This manual replaces and supersedes all previous versions as of Jan. 1, 2026. If you require further information about anything covered within this manual, or if you want to obtain a paper copy of this manual, which can be obtained at any time upon request, please call Humana Provider Services at **800-787-3311 (TTY: 711)**, Monday through Friday, 7 a.m. to 7 p.m., Central time.

Within this manual, key points are highlighted related to Humana policies and procedures. This manual is intended to inform both you and your staff of requirements for this plan, what Humana requires of you, and what you can expect from us. The guidelines set forth in this manual are designed

to assist you in the provision of caring, responsive services to your patients who are Humana members.

Except as may otherwise be set forth in your provider contract, you are contractually required to comply with all provisions contained in this manual. Revisions to this manual constate revisions to Humana's policies and procedures.

Any requirements under applicable law, regulation or guidance not expressly set forth in the content of this manual are incorporated herein by this reference and shall apply to providers and/or Humana where applicable. Such laws and regulations, if more stringent, take precedence over the content in this manual. You are responsible for complying with all applicable laws and regulations.

We may deny payment for any services or supplies for which you fail to comply with Humana's policies and procedures.

The provider manual is a comprehensive online reference tool for the provider and staff regarding, but not limited to, administrative, prior authorization, and referral processes, claims and encounter submission processes, and plan benefits. The provider manual also addresses topics such as clinical practice guidelines, availability and access standards, care management programs and enrollee rights pursuant to member rights, including members' rights not to be balance billed. Humana does not limit a provider's communication with members.

Manual updates and changes

Updates to this manual as permitted by the provider contract are posted on Humana's **Illinois provider website**. You may be notified of updates to this manual via fax or United States (U.S.) mail.

Acronyms

Acronym	Definition
ABA	Applied behavior analyst (analysis)
ADA	Americans with Disabilities Act
ADHD	Attention deficient hyperactivity disorder
AHA	American Hospital Association
AMA	American Medical Association
APA	American Psychiatric Association
ASAM	American Society of Addiction Medicine
ASC	Ambulatory surgical center
B2B	Business-to-business
BHC	Behavioral health clinic
BNI	Beneficiary notices initiative
CAC	Consumer advisory committee
CAH	Critical access hospitals

Acronym	Definition
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARES	Crisis and Referral Entry Service
CAR-T	Chimeric antigen receptor T-cell therapy
CDC	Centers for Disease Control and Prevention
CDS	Clinical decision support
CFR	Code of Federal Regulations
CHAT	Comprehensive health assessment tool
CHF	Congestive heart failure
CLAS	Culturally and linguistically appropriate services
CLIA	Clinical Laboratory Improvement Amendments of 1988
CMHC	Community mental health center
CMS	Centers for Medicare & Medicaid Services
COA	Care of older adults
COB	Coordination of benefits
COPD	Chronic obstructive pulmonary disorder
CORF	Comprehensive outpatient rehabilitation facility
COS	Categories of service
CPG	Clinical practice guidelines
CPT	Current Procedural Terminology
CQI	Continuous quality improvement
DENC	Detailed explanation of non-coverage
DME	Durable medical equipment
DND	Detailed notice of discharge
DPH	Department of Public Health
DRS	Division of Rehabilitation Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
D-SNP	Dual-eligible special needs plan
E/M	Medication management
EDI	Electronic data interchange
EFT	Electronic funds transfer
EMR	Electronic medical record
EOB	Explanation of benefits
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
ER	Emergency room
ERA	Electronic remittance advice
eRx	ePrescribing

Acronym	Definition
ESRD	End stage renal disease
EVV	Electronic visit verification
FAC	Federal Administrative Code
FDA	Food and Drug Administration
FFS	Fee-for-service
FIDE	Fully integrated dual eligible
FQHC	Federally qualified health center
FTP	File transfer protocol
HbA1c	Hemoglobin A1c
HCBS	Home- and community-based services
HCPCS	Healthcare Common Procedure Coding System
HCPR	Humana Clinical Pharmacy Review
HEDIS	Healthcare Effectiveness Data and Information Set
HFS	Healthcare and Family Services
HHA	Home health agency(ies)
HIPAA	Health Insurance Portability and Accountability Act
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HNS	Health needs screening
HRA	Health risk assessment
HSP	Home Services Program
HSPP	Health service provider in psychology
ICD	International Classification of Disease
ICP	Individualized care plan
ICT	Interdisciplinary care team
ID	Identification
IDOA	Illinois Department on Aging
ILAC	Illinois Legislative Action Committee
IM	Important Message from Medicare
IMD	Institution for mental disease
IMPACT	Illinois Medicaid program advanced cloud technology
IP	Inpatient
IPOC	Interdisciplinary plan of care
IRO	Independent review organization
IVR	Interactive voice response
LCAC	Licensed clinical addiction counselor

Acronym	Definition
LCD	Local coverage determination
LEA	Local education agency
LEP	Limited English proficiency
LLC	Limited liability corporation
LOCC	Level of care criteria
LTAC	Long-term acute care
LTC	Long-term care
LTSS	Long-term services and supports
MA	Medicare Advantage
MAT	Medication assisted treatment
MCD	Medicare Coverage Database
MCE	Managed care entity
MCG	Milliman Care Guidelines
MCR	Mobile crisis response
MDPP	Medicare diabetes prevention program
MHPAEA	Mental Health Parity and Addiction Equity Act
MHS	Member health screening
MLR	Medical loss ratio
MMA	Medicare-Medicaid Aligned
MMIS	Medicaid Management Information System
MOC	Model of care
MOON	Medicare outpatient observation notice
MPC	Medical payments coverage
MPL	Master provider list
MTM	Medication therapy management
NAIC	National Association of Insurance Commissioners
NCD	National coverage determination
NCQA	National Committee for Quality Assurance
NFLOC	Nursing facility level of care
NIH	National Institutes of Health
NOMNC	Notice of Medicare Non-Coverage
NOTICE Act	Notice of Observation Treatment and Implication for Care Eligibility Act
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NUBC	National Uniform Billing Committee

Acronym	Definition
OP	Outpatient
OPR	Ordering/referring provider
OT	Occupational therapy
OTC	Over the counter
OTP	Opioid treatment provider
OUD	Opioid use disorder
P2P	Peer to peer
PA	Prior authorization
PAD	Peripheral artery disease
PAL	Prior authorization list
PC	Procedure code
PCMH	Patient-centered medical home
PCP	Primary care physician
PDL	Preferred drug list
PERS	Personal emergency response system
PHI	Protected health information
PII	Personally identifiable information
PIP	Performance improvement plan
PIP	Personal injury protection
POS	Place of service
PQOC	Potential quality of care
PSA	Provider services agreement
PT	Physical therapy
QI	Quality improvement
QIC	Quality improvement committee
QIO	Quality improvement organization
QIP	Quality improvement project
QIPD	Quality improvement program description
QMI (QM&I)	Quality management and improvement
QMIC	Quality management and improvement committee
QMIP	Quality management and improvement program
RA	Remittance advice
RCP	Right Choices Program
RHC	Rural health center
SA	Sexual assault
SAC	Stakeholder advisory committee

Acronym	Definition
SCA	Single case agreement
SDOH	Social determinants of health
SET	Supervised exercise therapy
SHI	Sensitive health information
SME	Subject matter expert
SMI	Severe mental illness
SNF	Skilled nursing facility
SNP	Special needs plan
SSA	Social Security Act
ST	Speech therapy
SUD	Substance use disorder
TIN	Tax Identification Number
TTY	Teletypewriter
UM	Utilization management
U.S.	United States
USCA	United States Code Annotated
VA	Veterans Affairs
VAD	Ventricular assist device
WIC	Women, infants and children

Chapter 1: Introduction

General contact information

Contact name	Contact information	Hours of operation
Availity Essentials™	Phone: 800-282-4548 Website: Availity Essentials	Monday through Friday, 7 a.m. to 7 p.m., Central time
Humana Provider Services	Phone: 800-787-3311 (TTY: 711)	Monday through Friday, 7 a.m. to 7 p.m., Central time

About Medicaid

Medicaid provides healthcare coverage for income-eligible children, seniors, disabled adults and pregnant people. Medicaid services have been offered in the state of Illinois for more than 30 years.

Medicaid is funded by both the state and federal governments and includes both capitated health plans and FFS coverage. Medicaid is a program for eligible individuals and/or families with low income and/or resources. It is a means-tested program jointly funded by the state and federal governments and managed by the state.

Humana mission statement

We offer a whole-person approach to delivering healthcare to eligible recipients in Illinois aiming to help improve the health and well-being of members across the state while helping you provide quality care.

About Humana

Humana, headquartered in Louisville, Kentucky, is one of the nation's largest publicly traded full-service health, well-being solutions and supplemental benefits companies. Our affiliated health plans offer a wide array of health insurance and well-being products as well as government-sponsored plans. Over its more than 50-year history, Humana has consistently seized opportunities to meet changing customer needs. Today, Humana is a leader in consumer engagement.

We are honored to serve Humana Dual Fully Integrated members statewide.

We strive to make everything as straightforward as possible, facilitating high-quality care and creating a positive experience for everyone. We have a robust support structure for our provider network to deliver a best-in-class experience that is operationally efficient and ensures high-quality care. Humana is led by a president and chief executive officer and leadership team, as well as locally dedicated provider services staff and member support teams, including care coordinators and service coordinators. To build a strong relationship between Humana and its providers, **Humana Provider Services** will serve as your primary point of contact and happily answer any of your questions.

Humana distributes its member rights and responsibility statements to the following groups upon enrollment and annually thereafter:

- New members
- Existing members
- New providers

If you or your staff have questions or need help, please refer to the **Illinois Medicaid provider website** or reach out to **Humana Provider Services**. Thank you for partnering with Humana to improve the health and well-being of Illinois communities.

About this program

The Illinois Humana Dual Fully Integrated plan is designed to improve healthcare for dual-eligible Illinois beneficiaries. Jointly administered by the CMS and the Illinois HFS, the Humana Dual Fully Integrated plan allows eligible Illinois beneficiaries to receive Medicare Parts A, B and D benefits and Medicaid benefits from a single plan.

By integrating and coordinating healthcare benefits, Humana aims to:

- Improve quality and the beneficiary experience in accessing care
- Promote person-centered care planning
- Promote independence in the community
- Rebalance 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 will detail how you can request a hard copy of the communication at no charge. Our communications are kept up-to-date and in compliance with state and federal laws.

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

This manual and the Humana Dual Fully Integrated program

Thank you for your participation with Humana, where our goal is to provide quality services to members. This provider manual is a contract extension designed to highlight key points related to Illinois policies and procedures. We hope this manual will be a guideline for facilitation that informs you and your staff about the program's purpose, what you can expect from Humana and our behavioral health provider network, Carelon, and what we need from you as a network provider. The guidelines outlined in this provider manual are designed to help you provide caring, responsive service to our Humana Dual Fully Integrated members.

We look forward to a long and productive relationship with you and your staff. Should you require further assistance, please contact **Humana Provider Services**.

Accreditation

We demonstrate our strong commitment to quality through programs based on national standards, when applicable. Humana holds accreditation from the NCQA for our Medicaid lines of business.

Providers must agree to comply with Humana's quality assurance, quality investigation and peer review process, QI, accreditation, risk management, utilization review, UM, clinical trial and other administrative policies and procedures established and revised by Humana.

Compliance and ethics

We comply with applicable state and federal regulations, along with applicable Humana policies and procedures, as do our contracted providers. We are committed to conducting business in a legal and ethical manner, and we have an established compliance plan that:

- Formalizes our commitment to honest communication within the company and within the community, inclusive of our providers, members and employees
- Develops and maintains a culture that promotes integrity and ethical behavior
- Facilitates compliance with all applicable local, state and federal laws and regulations
- Implements a system for:
 - early detection and noncompliance reporting with laws and regulations
 - fraud, waste and abuse concerns
 - noncompliance with our policy or professional, ethical or legal standards
- Allows us to resolve problems promptly and minimize negative impact on our members or business, including financial losses, civil damages, penalties and sanctions

Our general compliance and ethics expectations for our contracted providers include:

- Acting according to professional ethics and business standards
- Notifying us of suspected violations, misconduct or fraud, waste and abuse concerns
- Cooperating fully with any investigation of alleged, suspected or detected violations of applicable state or federal laws and regulations
- Notifying us if you have any questions or require guidance for proper protocol

For questions about ethical and compliance expectations, please contact **Humana Provider Services**.

Provider websites

You can obtain plan information from our **Illinois Medicaid provider website**. From this website, you can find information related to:

- Claim processing edits
- Clinical practice guidelines
- Compliance training
- Coverage and claims
- Credentialing
- Dental benefits
- Drug list
- Grievances and appeals
- Health programs
- Humana Community Navigator® directory
- **Humana's provider publications website** (including the provider manual, Humana Physician News [quarterly newsletter] and program updates)
- In-person, video or telephonic interpretation services
- Language assistance resources
- Making It Easier tutorials
- Prior authorization search tool
- Value-based care report

Illinois-specific educational resources are also available on the **Illinois Medicaid provider website**.

These resources include the following:

- Annual training information
- Documents and forms
- Educational materials
- Pharmacy materials

- Provider notices and updates
- Quality resources

Availity Essentials provider portal

We partner with **Availity Essentials** to allow providers to reference member and claim data for multiple payers using a single sign-in. **Availity Essentials** provides access to the following:

- Certificates of coverage
- Claim submission and status
- Disputes and appeals
- Eligibility and benefits
- ERA/EFT enrollment
- Humana-specific applications, resources and news
- Medical record requests
- Member summary
- Overpayment management
- Plan of care
- Provider directory
- Referrals and authorizations
- Remittance advice
- Status of PA and referral requests

For more information, please reach out to **Availity Essentials**.

Humana Provider Services

We offer contracted providers access to **Humana Provider Services** which specializes in the following:

- Assisting all network providers in navigating available resources
- Helping providers access resources for billing and coding issues
- Educating providers regarding new policy changes, system updates, and access and availability standards
- Instructing on resolution processes and assisting with escalated issues
- Communicating important information with the provider network via meetings, newsletters, network notices and emails

Humana Provider Services will conduct a required yearly on-site visit to PCP offices to ensure compliance with and provide education on many requirements, including but not limited to:

- Access and availability standards

- Care management programs
- Cultural humility, health equity and implicit bias
- Encounter submissions
- Grievances and appeals processes
- HIPAA policies and procedures
- Member disenrollment processes
- Patient rights and responsibilities
- Privacy practices
- Provider resources

More information is available on the **Illinois Medicaid provider website** or you may contact **Humana Provider Services**.

Medicaid claims-related inquiries can be directed to **Humana Provider Services**, **Humana's claims payment information website** or **Availity Essentials**.

How to join our network

We would be honored to partner with you. If you don't yet participate in our network but are interested in joining, please refer to the following for more information:

- **Join our network**
- **Join Humana's dental provider network**
- **Join Humana's vision network via EyeMed**
- **Join Humana's behavioral health network**

Chapter 2: Member eligibility and enrollment

Contact information pertaining to member eligibility and enrollment

Contact name	Contact information	Hours of operation
Availity Essentials	Phone: 800-282-4548 Website: Availity Essentials	Monday through Friday, 7 a.m. to 7 p.m., Central time
Humana Provider Services	Phone: 800-787-3311, TTY 711	Monday through Friday, 7 a.m. to 7 p.m., Central time
Humana Care Management	Phone: 800-559-3917	Monday through Friday, 8 a.m. to 5 p.m., Central time

Member enrollment and eligibility

Humana Dual Fully Integrated is a statewide managed care program for eligible members in Illinois. Possession of a member ID card does not guarantee member eligibility. We strongly encourage providers to verify member eligibility frequently. Eligibility begins on the first day of each calendar month for members joining Humana.

Verifying member eligibility

Before providing all nonemergency services, you must verify member eligibility. You should ask members to present an ID card each time services are rendered. If you are not familiar with the member seeking care and cannot verify the person as a Humana member, you should ask to see photo ID. Eligibility can be verified through **Availity Essentials** → Patient Registration → Eligibility and Benefits Inquiry.

Member ID cards

All new Humana members receive a member ID card. A new card is issued only if the information on the card changes, the card is lost or an additional card is requested. The member ID card is used to

identify a Humana member but does not guarantee eligibility or benefits coverage because members may disenroll from Humana or lose Medicaid eligibility at any time. Therefore, it is important to verify member eligibility prior to rendering any service. Verification for Humana Dual Fully Integrated is completed by the enrollment broker and the state to ensure all eligibility requirements are met and correct.

Automatic renewal

If Humana members lose Medicaid eligibility but become eligible again within 90 calendar days, they are automatically reenrolled in our plan and if possible, are assigned the same PCP. As a reminder, you are encouraged to verify a patient's eligibility via **Availity Essentials** before providing services.

New member kits

Within 5 business days of enrolling in a Humana Dual Fully Integrated plan, each new member household receives a new member kit, and each person in the household receives an ID card. New member kits are mailed separately from the ID card.

The new member kit contains:

- A welcome letter, including education confirming the member's enrollment and information about coordination of care with current providers and how the member can receive care coordination assistance
- A quick start guide, including information about how to get started using the plan, like creating a Go365 by Humana account and registering for MyHumana.com
- Information about programs and services, pharmacy services, coverage information, and our digital tools designed to improve member engagement
- A health assessment survey
- Optional forms regarding privacy and continuity of care

Members will be notified through member communications and the quick start guide on how to request a one-time hard copy of important plan documents like the Member Handbook/EOC, provider/pharmacy directory, formulary, summary of benefits, and other plan documents and forms. The provider directory is also accessible through our Find a Doctor service.

Member services

Humana will assist members who have questions or concerns about benefits and services. Representatives are available by telephone through **Humana Provider Services**. Representatives are not available on Humana-observed holidays. If the holiday falls on a Saturday, Humana will be closed the Friday before. If the holiday falls on a Sunday, we will be closed the Monday after.

PCP assignment

A PCP will be assigned automatically to all Illinois Humana Dual Fully Integrated-only members who do not self-select a PCP. Humana will utilize the PCP assignment history file for assignment. If a PCP is not provided, Humana's internal enrollment system will identify a member's previous PCP within the participating Humana PCP panel and assist through auto assignment. Geographic assignment will be used when a member has no record of past PCP relationships within the participating Humana PCP panel or the PCP assignment history file.

Member-initiated PCP changes

Members select a PCP from Humana's **provider directory**. Members have the option to change to another participating PCP with cause as often as needed. Members can initiate this change by contacting **Humana Provider Services**. PCP changes are effective on the first day of the month following the requested change.

Member request for a new provider

Members have the right to choose a provider who meets their needs. To find a doctor, specialist, hospital, healthcare facility or other type of in-network service provider, members may contact **Humana Provider Services** or access Humana's **provider directory**.

Member disenrollment

Humana Dual Fully Integrated members can change to or from a Humana plan only at the following intervals:

- Once per calendar year, for any reason
- During the Medicare open enrollment window¹ to be effective the following calendar year

Members may leave Humana for just cause. Determination about whether the member has met the conditions for just cause is solely the determination of the enrollment broker and the state. Valid just-cause conditions include but are not limited to the following:

- Receiving poor quality of care or circumstances determined by the office or its designee to constitute poor quality healthcare coverage
 - Poor quality of care includes failure to comply with established standards of medical care administration and significant language or cultural barriers.
- Failure to provide covered services
- Failure of Humana to comply with established standards of medical care administration

¹ CMS.gov. (2025). Medicare open enrollment. <https://www.cms.gov/priorities/key-initiatives/medicare-open-enrollment-partnesources>

- Lack of access to providers experienced in dealing with the member's healthcare needs
- Significant language or cultural barriers
- Corrective action levied against Humana
- Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence
- Determination that another MCE's formulary is more consistent with a new member's existing healthcare needs
- Lack of access to medically necessary services covered under the MCE's contract with the state
- A service not covered by the MCE for moral or religious objections
- Related services required to be performed at the same time and not all related services available within the MCE's network and member's provider determines receiving services separately will subject member to unnecessary risk
- The member's PCP disenrolls from the member's current MCE and reenrolls with another MCE
- If a member's PCP disenrolls from the member's current MCE and reenrolls in a new MCE, the member can change plans to follow the member's PCP to the new MCE.

Members must file a grievance with Humana before a determination will be made upon their just-cause request. If the member remains dissatisfied with the outcome, the member can contact the enrollment broker to request disenrollment. Members may submit requests to change their MCE to the enrollment broker verbally or in writing. The MCE shall provide the enrollment broker's contact information and explain that the member must contact the enrollment broker with questions about the process.

The enrollment broker reviews the request and makes a disenrollment recommendation. In making the disenrollment recommendation, the enrollment broker will review a copy of the member's grievance and appeal record from Humana to ensure the grievance and appeal process was exhausted. All enrollment broker reviews that result in a recommendation to approve disenrollment are then sent to the state, which makes the final determination on the request.

Members may be disenrolled from Humana for several reasons. If a member loses Medicaid eligibility, the member is no longer eligible for coverage through Humana. Humana, the state or the member can initiate disenrollment, which may be initiated for the following:

- Unauthorized use of a member ID card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the ability to deliver care to the member or to other patients

Please notify **Humana Provider Services** if any of these situations occur. Procedures for dismissing noncompliant members from your practice are outlined in the **Involuntary Dismissal section of this provider manual**. Humana may counsel the member, or in severe cases, initiate a request to the state for disenrollment. It is at the state's discretion as to whether it will initiate disenrollment. Disenrollment from Humana always occurs at the end of the effective month.

Involuntary dismissals

Participating providers can request that a Humana member be involuntarily dismissed from their practice and assigned a new PCP for the following:

- Incompatibility of the provider/patient relationship
- Member has not used a service within 1 year of enrollment in the PCP's practice, and the PCP has documented unsuccessful contact attempts by mail and phone on at least 6 separate occasions during the year
- The provider's inability to meet the medical needs of the member
- Member is incarcerated

You must follow the following Humana policy requirements to request involuntary dismissal of a member from your practice:

- A. Attempt communication in person, by mail and/or by phone with the member, and document attempts within the member's medical record.
 - a. Make 3 communication attempts regarding incompatibility of the provider/patient relationship where the member does not respond to recommended patterns of treatment or behavior, including:
 - i. Noncompliance with medication schedules
 - ii. Violating office no-show policies
 - iii. Failing to modify behavior as requested
 - b. Make 6 communication attempts when the member has not used a service within 1 year of enrollment in the PCP's practice.
 - c. Communicate at least 1 time regarding your inability to meet the medical needs of the member.
- B. Notify the member of the member's dismissal by certified letter, which must include the following details:
 - a. The reason for which their disenrollment was requested
 - b. The specific dates of the documented unsuccessful education/communication attempts and/or communication that you are unable to meet the member's needs
 - c. If you are a PCP, notification of the phone number the member must call to choose another PCP
- C. You must submit the member dismissal notice to Humana for review and approval prior to sending the notice to the member to ensure all requirements have been met.

A copy of this letter must be mailed or faxed to the **Grievances and Appeals department**. Barring ethical or legal issues, the dismissing provider must serve the affected patient until a new provider can serve the patient. When a member misses 3 or more consecutive appointments, providers may request assistance from **Humana Care Management**. Providers do not have the right to request a member's disenrollment from their practice for the following:

- Change in the member's health status or need for treatment
- Member's utilization of medical services
- Member's diminished mental capacity
- Disruptive behavior that results from the member's special healthcare needs unless the behavior impairs the ability of the PCP to furnish services to the member or others

Transfer requests shall not be based on member's race, ethnicity, sexuality, national origin, disability, age or gender.

Referrals for release due to ethical reasons

Humana has no moral or religious objections for providing any covered services. However, you are not required to perform treatments or procedures contrary to your conscience, religious beliefs or ethical principles.² Humana will inform members of the decision not to cover the requested service and how to access the requested service from another provider.

You must refer the member to another provider who is licensed, certified or accredited to provide care for the individual service appropriate to the member's medical condition. The provider must be actively enrolled with the state to provide Medicaid services to beneficiaries and must also be in Humana's provider network.

In such circumstances, where your conscience, religious beliefs or ethical principles require involuntary dismissal of the member, your office must notify the member of the dismissal by certified letter.

- The letter must include:
 - The reason for the disenrollment request
 - A referral to another provider that is licensed, certified or accredited to provide care for the individual service appropriate to the patient's medical condition
 - Instructions for the member to contact **Humana Provider Services** for assistance in finding a preferred in-network provider.

A copy of this letter must be mailed or faxed to the **Grievances and Appeals department**.

Please call **Humana Provider Services** if you have questions about disenrollment reasons or procedures.

² 42 C.F.R. § 438.102

Chapter 3: Member rights and responsibilities

As a Humana provider, you are required to respect the rights of our members, who are informed of their rights and responsibilities³ via their member manual. We have also included the list of member rights and responsibilities below for your reference. Care managers provide members with information about their rights and responsibilities at the time of enrollment and annually.

Contact information pertaining to member rights and responsibilities

Contact name	Contact information	Hours of operation
Humana Provider Services	Phone: 800-787-3311 (TTY: 711)	Monday through Friday, 7 a.m. to 7 p.m., Central time

Member rights

All members are encouraged to take an active and participatory role in their own health and the health of their family.

Members have the right to:

- Be free from all forms of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion
- Request and receive a copy of their medical records and request that they be amended or corrected, as per rules set forth in 45 C.F.R parts 160 and 164 subparts A and E, and as specified in 45 C.F.R § 164.524 and § 164.526
- A candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage
- Be advised—before care is initiated—of the cost of services and the extent to which payment may be required by the member
- Be afforded the opportunity to participate in the development of the care plan and to refuse treatment without retribution, while being fully informed of the possible medical consequences of refusal

³ 42 C.F.R. § 438.100; 42 C.F.R. § 422 Subpart C; memorandum of understanding between CMS and the state of Illinois

- Be assured of the confidentiality of records and to approve or refuse the release of information not authorized by law
- Be assured that qualified personnel will present proper identification at the time of a visit
- Be fully informed by a physician of health status, unless medically contraindicated
- Be fully informed in advance of all care and treatment to be provided by the service provider, changes in care or treatment and to receive a copy of their plan of care if they request
- Be fully informed of services available from the service provider and how to access care
- Be furnished healthcare services in accordance with 42 C.F.R § 438.206
- Be informed of the state hotline number with hours of operation and purpose for obtaining information on HHA
- Be served without regard to race, color, creed, sex, age, national origin, ancestry or handicap/disability
- Be treated with respect, dignity, privacy, confidentiality, accessibility and be free from discrimination
- Direct their care with their own staff and/or providers
- File a grievance without fear of discrimination or reprisal from the service provider
- Make recommendations regarding the organization's member rights and responsibilities policy
- Make recommendations to the Humana member rights and responsibilities policy
- Receive HBCS in a home-like environment and participate in their communities regardless of their living arrangements
- Receive information about Humana, its services, its providers, and member rights and responsibilities
- Receive information about the plan, its services, its practitioners and providers, and member rights and responsibilities.
- Receive information in accordance with 42 C.F.R § 438.10
- Take an active part in discussions about the member's healthcare unless it is not in their best interest
- Voice complaints or appeals about the plan or the care it provides
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition, functional status and language needs
- Have all plan options, rules and benefits fully explained, including through use of a qualified interpreter if needed
- Access to an adequate network of primary and specialty providers who can meet the member's needs with respect to physical access and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting

- Receive a second opinion on a medical procedure and have Humana pay for the second opinion consultation visit
- Choose a plan and provider at any time and have that choice be effective the first calendar day of the following month
- Have a voice in the governance and operation of the integrated system, provider or health plan
- 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 an in-person comprehensive assessment upon enrollment in a plan and participate in the development and implementation of an IPOC. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the member's strengths and weaknesses, and a plan for managing and coordination member's care. Members, or their designated representative, also have the right to request a reassessment by the interdisciplinary team and be fully involved in any such reassessment.
 - Receive complete and accurate information on their health and functional status by the interdisciplinary team
 - Be provided with information on all program services and healthcare options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking into consideration member's condition and ability to understand. A member who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
 - Before enrollment
 - At enrollment
 - At the time a potential member's or member's needs necessitate the disclosure and delivery of such information in order to allow the potential member or member to make an informed choice
 - Be encouraged to involve caregivers or family members in treatment discussions and decisions
 - Have advance directives explained and establish them, if the member so desires, in accordance with 42 C.F.R. §§ 489.100 and 489.102
 - Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer
 - Be afforded the opportunity file an appeal if services are denied that the member thinks are medically indicated, and to be able to ultimately take that appeal to an independent external system of review
- 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

Member responsibilities

Members have a responsibility to:

- Accept services of service provider staff, without regard to race, creed, color, religion, national origin, handicap, sex or age
- Follow the advice and instructions for care which they have agreed upon with their healthcare provider
- Have a PCP who will provide orders (as required) for skilled home-care treatments and services
- Have a plan for management of emergencies and access the plan, if necessary for safety
- Inform the service provider about changes in health status, medications or treatments
- Inform the service provider of the presence of advance directives and provide copies, as appropriate
- Inform the state of any change in financial status that may affect reimbursement for home care
- Participate in reaching goals the member and the member's healthcare provider agree upon
- Participate with the plan of treatment with which they have agreed, when possible, and make available an informal caregiver assume primary care, as appropriate
- Provide accurate and complete medical and health history information as they understand it
- Report fraud, abuse and overpayment
- Understand as much as they can about their health issues

Chapter 4: Provider rights and responsibilities

Contact information pertaining to provider rights and responsibilities

Contact name	Contact information	Hours of operation
Humana Concierge Service for Accessibility	Phone: 877-320-2233 Website: Accessibility Resources on Humana.com	Monday through Friday, 7 a.m. to 7 p.m., Central time,
Humana Provider Services	Phone: 800-787-3311 (TTY: 711)	Monday through Friday, 7 a.m. to 7 p.m., Central time

Provider responsibilities

You are expected to treat members with respect. Our members should not be treated differently than patients with other healthcare insurance. Please refer to the **Member Rights and Responsibilities section of this provider manual** for more information.

You are expected to make daily visits to your patients who are admitted as IP to an acute care facility, or you can arrange for a colleague to visit. Participating PCPs are also expected to have a system in place for following up with patients who miss scheduled appointments.

We expect you to verify member eligibility and ask for members' healthcare insurance information before rendering services, except in an emergency. You can verify member eligibility and obtain information for other healthcare insurance coverage by accessing **Availity Essentials**. For all Medicaid services provided by Humana that require the completion of a specific form (e.g., hospice, sterilization, early elective delivery, hysterectomy or abortion), the respective form must be completed and submitted with the procedure claim or initial hospice claim. Claims are not paid until you submit the completed form. The completed forms should be included in the member's chart in the event of audit and, on request, a copy should be submitted to the state. Please see the **Illinois Medicaid provider website** for more information.

Provider rights

As a Humana participating provider, you agree to:

- Provide a health screening evaluation consisting of comprehensive health and developmental history, including past medical history assessment
- Provide developmental history behavioral health status
- Conduct a comprehensive unclothed physical examination
- Conduct developmental assessment
- Conduct nutritional assessment
- Immunize as required by the appropriate CDC Recommended Childhood Immunization Schedule
- Offer health education, including anticipatory guidance
- Conduct a dental screening, including a direct referral to a dentist for members beginning at 3 years of age or earlier as indicated
- Conduct a vision screening, including objective testing as required
- Conduct a hearing screening, including objective testing as required
- Provide diagnosis and treatment utilizing a trauma-informed care approach
- Provide referral to a specialist as needed and follow-up as appropriate
- Understand and agree that provider performance data can be used by Humana

Additional responsibilities of behavioral health service providers

- All members receiving IP behavioral health services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within 7 business days of the date of discharge.
- Behavioral health network providers must notify the MCE within 5 calendar days of the member's visit, and submit information about the treatment plan, the member's diagnosis, medications and other pertinent information.
- Every network provider, including behavioral health providers, should ask and encourage members to sign a consent form that permits release of SUD treatment information to Humana and to the PCP or behavioral health provider, if applicable.
- Providers must participate in not less than quarterly continuity of care meetings hosted by Humana and/or state-operated or state-contracted (psychiatric) facilities.
- Providers must participate in discharge planning meetings with Humana's assigned care coordinators.

Additional responsibilities of PCPs

PCPs are responsible for:

- Supervising, coordinating and providing initial and primary care to members
- Initiating referrals for specialty care as needed

- Maintaining the continuity of member care 24 hours a day

In addition, Humana PCPs play an integral part in coordinating healthcare for our members by providing:

- Assistance with coordinating a member's overall care, as appropriate for the member
- Continuity of the member's total healthcare
- Early detection and preventive healthcare services
- Elimination of inappropriate and duplicate services

PCP care coordination responsibilities include, at a minimum, the following:

- Treating Illinois Humana Dual Fully Integrated members with the same dignity and respect afforded to all members including standards of care and hours of operation
- Maintaining continuity of the member's healthcare
- Identifying the member's health needs and taking appropriate action
- Providing phone coverage for handling member calls 24 hours a day, 7 days a week
- Refer to the **appointment standards section** for more details.
- Making referrals for specialty care and other medically necessary services, both in and out of network, when such services are not available within the Humana network
- Following all PA policies and procedures as outlined in this manual
- Complying with the quality standards of Humana and the state as outlined in this manual
- Discussing advance medical directives with members as appropriate
- Maintaining clinical records, including information about pharmaceuticals, referrals, IP history and documentation of all PCP and specialty care services, etc., in a complete and accurate medical record that meets or exceeds state specifications
- Obtaining member records from facilities visited by Humana-covered members for emergency or urgent care if notified of the visit
- Ensuring demographic and practice information is up to date for directory and member use
- Referring members to behavioral health providers and arranging appointments, when clinically appropriate
- Assisting with coordination of the member's overall care, as appropriate for the member
- Recommending referrals to specialists, as required
- Participating in the development of care management care plans and notifying Humana of members who may benefit from care management
- Understanding and agreeing that provider performance data can be used by Humana
- Maintaining formalized relationships with other PCPs to refer their members for after-hours care, during certain days and for certain services or other reasons to extend their practices
- Forwarding medical records or copies of records when a member changes a PCP to the new PCP or practice within 10 calendar days of the receipt of request

- The PCP's office shall have the member sign a release of medical records before a medical record transfer occurs.

Equal 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.

ADA compliance

All Humana-contracted healthcare providers must comply with the ADA, as well as all applicable state and/or federal laws, rules and regulations. More details are available in your provider contract under Compliance with Regulatory Requirements. We develop ICPs that consider members' special and unique needs. Members in need of interpretation services can call the number on the back of their member ID cards or visit our [accessibility resources website](#) to schedule interpretation services at least 48 hours prior to an appointment. If your patient requires interpretive services, you may contact **Humana's Concierge Services for Accessibility** with date, time, your phone number and the appointment location. Please do not include patient health information when emailing. While interpreters may be available on demand, this cannot be guaranteed and thus scheduling interpretation services in advance is preferred. Oral interpretation services are provided free to you when communicating with Humana members.

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

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 ensure required ADA compliance.

Consideration and accommodation of member special needs

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 just some of the challenges our members face daily. Healthcare providers must also meet all accessibility requirements specified by their Humana contracts. Humana's minimum provider agreement requirements include the following:

- Provide physical access, reasonable accommodations and accessible equipment for members with physical or mental disabilities.⁴
- Identify provider locations that provide physical access, accessible equipment and/or reasonable accommodations for members with physical or cognitive disabilities.

More details are available within your Humana provider agreement. Humana's provider directory contains information about:

- Physical accessibility
- Accessible equipment
- Reasonable accommodations for members with physical or cognitive disabilities

Additional educational resources are available on our **communication assistance** and **accessibility support** websites to help you learn more about ADA requirements and best practices for maintaining accessible and inclusive practices, such as tips and suggestions for providing inclusive and member-centric care to those with intellectual disabilities, speech impairments or difficulties, and more.

Multidisciplinary integration and person-centered care planning

In recognition of 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. Members are 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.

Members should also receive clear information about:

- Their health conditions and functional limitations

⁴ 42 C.F.R. § 489.102(a)(4)

- 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 barriers to care encountered by the 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 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.

Nondiscrimination

Humana is an equal opportunity organization. Provider participation decisions are nondiscriminatory and based on merit and business needs, not race, color, national origin, disability, age or gender or any other factor protected by law.

Humana employs a member advocate/nondiscrimination coordinator to support and ensure members receive their services in a nondiscriminatory manner. Providers will not discriminate against any member based on race, color, age, national origin, sex, sexual orientation, gender identity, genetic information, income status, Humana Dual Fully Integrated membership or disability and will not use any policy or practice that has the effect of discriminating in such manner.

Affirmative action, diversity and cultural competency

We are committed to embracing diversity in the provision of member services and providing fair and equal opportunities for all qualified minority businesses. Humana wishes to accommodate religious

and cultural preferences of all members and will seek provider input that might be useful in meeting member preferences. To request a free paper copy of Humana's Cultural Competency Plan, please contact **Humana Provider Services**.

You are responsible for arranging oral interpretation services for members seeking healthcare-related and LTSS services in your office or service location. Providers that provide 24-hour access to healthcare-related services in their location or via telephone, such as PCPs and hospital emergency departments, must provide members with 24-hour oral interpreter services, either through interpreters or telephone services, for example, TTY services for hard-of-hearing members, oral interpreters and American Sign Language interpreters. If you have members who require interpretive services, you may contact **Humana Concierge Services for Accessibility**.

Humana conducts site surveys of all office locations that include PCPs and gynecologists during initial credentialing and again every 3 years during recredentialing. Defined high-volume specialist office locations also will receive a site survey during recredentialing. The site survey will assess office compliance with Humana's organizational standards, including ADA compliance, accessibility and accommodations for members with physical or cognitive disabilities.

PCP role

All Humana members choose or are assigned to a PCP upon plan enrollment. PCPs help facilitate a "medical home" for members, meaning that PCPs help coordinate healthcare for the member and provide additional health options to the member for self-care or care from community partners. PCPs are also required to screen and refer members for behavioral health conditions. Please refer to the **Behavioral Health section of this provider manual** for more information.

Members select a PCP from our provider directory. Members have the option to transition to another participating PCP as often as needed. Members initiate the change by calling **Humana Provider Services**. PCP changes are effective on the first day of the month following the requested change.

When members change PCPs, the medical records or copies of medical records should be forwarded to the new PCP within 5 business days. The PCP is required to have members sign a release of medical records before a medical record transfer occurs.

PCP assignment

PCP assignment and changes

Members select a PCP from our provider directory. Members have the option to change to another participating PCP as often as needed. Members initiate the change by calling **Humana Provider Services**. PCP changes are effective on the first day of the month following the requested change. When members change PCPs, the medical records or copies of medical records should be forwarded to the new PCP within 5 business days of receipt of request. The PCP is required to have members sign a release of medical records before a medical record transfer occurs.

Advance directives

Provider responsibility

An advance directive is “a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is incapacitated.”⁵ Advance directives are essential for providing patient-centered care and should be charted in Illinois Humana Dual Fully Integrated members’ permanent medical records. Humana providers are responsible for discussing advance directives during the first appointment with adult members of sound mind.

The PCP should discuss potential medical emergencies with the member and document that discussion in the member’s medical record. A copy of the advance directive should be included in the member’s medical record inclusive of other mental health directives.

All member records shall contain documentation showing the member received written information concerning the member’s rights regarding advance directives (written instructions for living will or power of attorney), including whether the member has executed an advance directive.

Humana and its providers will not condition the provision of care or otherwise discriminate against a member based on whether the member has executed an advance directive.

Providers must inform individuals that complaints concerning the advance directive requirements may be filed with the Illinois Department of Health.⁵

Member rights and advance directives

Members have a voice in the care they receive. Advance directives ensure members’ healthcare needs are met if they are unable to communicate. Members are encouraged to communicate their wishes with their family and medical team.

Other significant Humana policies affecting providers

For more information about advance directives and to locate available forms, please direct members to the **Illinois Department of Public Health advance directives website**.

- More information CLIA certification requirements is available in the **credentialing and recredentialing chapter of this provider manual**.
- Humana will accept into the network:
 - Any SNF that agrees to Humana’s standard provider agreement and meets all applicable state and federal participation requirements for the first 3 years of the program
 - Any LTSS provider that agrees to the contractor’s standard provider agreement and meets all applicable state and federal participation requirements for the first 3 years of the program

Humana notifies providers of participation agreement (i.e., contract) termination or nonrenewal according to the terms outlined in the participation agreement, or if not specified, then no less than

⁵ 42 C.F.R. § 489.102(a)(4)

90 calendar days prior to the effective termination date or as required by state or federal regulations or accreditation requirements. Providers must provide Humana with notice according to the terms outlined in the participation agreement regarding any termination or nonrenewal to allow Humana to comply with the member notification time frames required by applicable state and/or federal law, accreditation standards and the state contract requirements. The notification to Humana must be in writing and comply with the contractual requirements for notice to initiate the participation agreement termination. Please refer to your provider agreement for more details.

Appointment wait time and access standards and requirements

We have adopted service standards regarding the availability of participating provider services. You are expected to maintain these standards as outlined in your contract. Hours of operation should be no less than the hours of operation that are offered to members with other health plans, such as commercial and Medicare.

Participating PCPs and specialists 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 is not permitted). Members should be triaged and provided appointments for care within the following time frames:

Service	Appointment standards
Urgent care	Within 1 business day when medically necessary
Routine sick member care	Within 3 weeks of the date of a request
Well-care and routine visits	Within 25 business days of making a request
Problems or complaints not deemed serious but requiring medical attention	Within 7 business days of making a request
Problems or complaints not deemed serious	Within 3 weeks of making a request
First trimester prenatal visits without expressed problems	Within 2 weeks of a request
Second trimester prenatal visits without expressed problems	Within 1 week of a request
Third trimester prenatal visits without expressed problems	Within 3 calendar days of a request

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

Compliance with availability and accessibility standards are monitored regularly through random sampling, review of member concerns and member satisfaction surveys to ensure members have reasonable access to providers and services.

PCMH

Participating 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 QI.

For more information on how your practice can become a PCMH, please contact **Humana Provider Services**.

Requirements for after-hours availability

PCPs must provide after-hours coverage available 24 hours a day, 7 days a week. PCPs or a designated provider must answer member phone calls after normal business hours in English and Spanish.

After-hours coverage may include an answering service or a shared-call service with other medical providers. Voicemail is not permitted. Members should be triaged and provided appointments for care within the time frames outlined above.

Missed appointments

When members miss scheduled appointments, your office is responsible for contacting the member within 24 hours to attempt to reschedule the appointment. You are responsible for documenting communication attempts in the member's file.

Behavioral health appointment accessibility standards

Please keep in mind the following behavioral health appointment accessibility standards.

Participating providers are expected to have procedures in place to see members within these time frames and to offer office hours to their Humana-covered patients that are at least the equivalent of those offered to all other patients. Humana will monitor appointment time compliance using secret shopper surveys in accordance with contractual requirements.

Humana and their providers are not held responsible if the member or provider voluntarily chooses to schedule an appointment outside of the specified time frames.

Behavioral health providers

Patients in need of	Should be seen
Emergency care with crisis stabilization	Immediate access
Urgent care	Immediate access
Post discharge from acute hospitalization	Within 7 calendar days of discharge
Other routine referrals or appointments	Within 25 business days
Initial outpatient appointment for mental, emotional, nervous, or substance use disorders or conditions	Within 10 business days of the request
Follow-up outpatient appointments for treatment of mental, emotional, nervous, or substance use disorders or conditions	Within 20 business days of the request

Provider accessibility monitoring

Humana will annually, or sooner when directed by the state, conduct surveys to assess the accessibility and availability of provider services outside of normal business hours. The survey will assess the members' ability to contact the PCP 24 hours a day, 7 days a week for emergent and urgent needs, to include holidays.

Provider-based marketing activities

You may advertise or utilize marketing materials, logos, trade names, service marks or other materials created or owned by Humana after obtaining Humana's written consent. You cannot acquire any right or title to Humana-approved materials.

You must remain aware of and in compliance with the following requirements:

- You may display health-plan-specific materials in your own offices. You are permitted to make available and/or distribute Humana marketing materials as long as you and/or your facility distribute or make available marketing materials for all managed care plans with which you participate.
- If you agree to make available and/or distribute Humana marketing materials, you should do so knowing you must accept future requests from other plans with whom you participate.
- You are also permitted to display posters or other materials in common areas such as the waiting room.
- LTC facilities are permitted to provide materials in admission packets announcing all contractual relationships with managed care plans.

- You may not orally or in writing compare benefits or provider networks among health plans, other than to confirm whether providers participate in a health plan's network. If you can assist a recipient in an objective assessment of your needs and potential options to meet those needs, you may do so. You may engage in discussions with members should a member seek advice. However, you must remain neutral when assisting with enrollment decisions.
- You may announce a new affiliation with a health plan through general advertising (e.g., radio, television, websites) once a contract is signed. You may also provide members a list of health plans with whom they are contracted.
- You may cosponsor events, such as health fairs, and advertise with the health plan in indirect ways, such as television, radio, posters, flyers and print advertisements.
- You shall not furnish lists of your Medicaid recipients to Humana or any other entity.
- You shall not furnish other health plans' membership lists to Humana; nor can you assist with health plan enrollment.
- For Humana, you may distribute information about non-health-plan specific healthcare services and the provision of health, welfare and social services by the state or local communities as long as inquiries from prospective members are referred the member services section of the health plan or the state.
- You may refer your members to other sources of information, such as the managed care plan, the enrollment broker or the local Medicaid area office. You may also share information from the state or CMS website with members.

You must not:

- Offer marketing/appointment forms
- Make phone calls or direct, urge or attempt to persuade members to enroll in a particular health plan based on financial or any other interests you may have
- Mail marketing materials on behalf of a particular plan
- Offer anything of value to induce recipients/members to select you as their provider
- Offer inducements to persuade recipients to enroll in a particular plan
- Conduct health screenings as a marketing activity
- Accept compensation directly or indirectly from any managed care plan for marketing activities
- Distribute marketing materials within an exam room setting, hospital patient rooms, or treatment areas where patients interact with a provider and clinical team
- Furnish lists of your Medicaid members or the membership of any managed care plan to a managed care plan

Requirements regarding community outreach activities and marketing prohibitions

Humana and its subcontractors shall not:

- Seek to influence enrollment in conjunction with the sale or offering of any private insurance⁶
- Directly or indirectly, engage in door-to-door, telephone or other cold-calling marketing activities⁷
- 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 benefits⁸
- Make any inaccurate, false or misleading claims that Humana is recommended or endorsed by any federal, state or county government, the Illinois Department of Healthcare and Family Services, CMS or department of any other organization that has not certified its endorsement in writing to Humana⁹

Notification of demographic changes

As a network provider, you are responsible for notifying us of demographic changes as outlined in this provider manual and under the terms of your contract with Humana.

Notify **Humana Provider Services** immediately of changes, such as:

- Demographic changes (e.g., telephone, fax, email, or administrative staff changes)
- Name and ownership change (35-day notice)
- New member indicator
- Physical address change
- Tax identification/billing address change (W-9 required)

This notification will ensure your information is properly listed in the provider directory and all payments made are properly reported to the Internal Revenue Service. Failure to comply with this section could lead to a delay in payments. In the event there are changes that will affect your ability to provide services to our members, please notify **Humana Provider Services** immediately.

HIPAA compliance

The task of handling member records and related administrative functions is accomplished in strict compliance with HIPAA. Member files are kept confidential at all times. Providers should take some or all of the following precautions:

- Only request and work with PHI related to treatment, payment or healthcare operations.
- Email should not be used to transfer files with member info unless encrypted.

⁶ 42 C.F.R. § 438.104(b)(1)(iv)

⁷ 42 C.F.R. § 438.104(b)(1)(v)

⁸ 42 C.F.R. § 438.104(b)(2)(i)

⁹ 42 C.F.R. § 438.104(b)(2)(ii)

- Fax machines should be positioned for privacy.
- Fax numbers should be confirmed before sending information to Humana.
- Leave minimum data on voicemail.

To be compliant with HIPAA, providers should make reasonable efforts to restrict access and limit routine disclosure of PHI to the minimum necessary to accomplish the intended purpose of the disclosure of patient information. If a Humana-covered member changes their PCP for any reason, you must transfer a copy of the patient's medical record to the patient's new PCP at the request of the plan or the patient. The contract states whether the original or a copy of the medical record must be sent. If you terminate, you are responsible for transferring the patients' medical records. Charges for copying medical records are considered a part of office overhead and medical records are to be provided at no cost to Humana-covered patients and Humana, unless state regulations or the contract stipulate otherwise.

Personally identifiable information and PHI

In the day-to-day business of patient treatment, payment and healthcare operations, Humana and its providers routinely handle large amounts of PII. In the face of increasing identity theft, there are various standards and industry best practices that guide how PII is appropriately protected when stored, processed and transferred while conducting normal business. As a provider, you should take measures to secure your patients' data.

You are also mandated by HIPAA to secure all PHI related to your patients. There are many administrative, physical and technical controls you should have in place to protect all PII and PHI.

Here are some important places to start:

- Utilize a secure message tool or service to protect data sent by email.
- Have policies and procedures in place to address the protection of paper documents containing patient information, including secure storage, handling and destruction of documents.
- Encrypt all laptops, desktops and portable media such as CD-ROMs and USB flash drives that may potentially contain PHI or PII.

Member privacy

The HIPAA Privacy Rule requires health plans and covered healthcare providers to develop and distribute a notice that provides a clear, user-friendly explanation of individuals' rights with respect to their personal health information, as well as the privacy practices of health insurance plans and healthcare providers.

You must follow the HIPAA regulations and make only reasonable and appropriate uses and disclosures of PHI for treatment, payment and healthcare operations.

Member consent to share health information

- Consent is the member's written permission to share their information. Not all disclosures require the member's permission. The following are consent requirements that pertain to SHI and SUD treatment:

- SHI is defined by the state (e.g., HIV/AIDS, mental health, sexually transmitted diseases).
- Confidentiality of substance use disorder patient records: 42 C.F.R Part 2 pertains to federal requirements that apply to all states. While all member data is protected under the HIPAA Privacy Rules, Part 2 provides more stringent federal protections to protect individuals with SUDs who could be subject to discrimination and legal consequences in the event their information is inappropriately used or disclosed. The state requirements provide more stringent protections for the sharing of certain information determined to be SHI.
- When consent is on record, Humana displays all member information on **Availity Essentials** and any health information exchanges. Please explain to your patients that if they do not consent to let us share this information, the providers involved in their care may not be able to effectively coordinate their care. When a member does not consent to share this information, a message displays on the provider portal to indicate that all the member's health information may not be available to all providers.

Confidentiality statement

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

Provider training

Humana requires adherence to all compliance-based training programs. This includes contract and assurance that all affiliated participating providers, along with supporting healthcare providers and staff with member interaction, receive training on the identified compliance material. Member interaction can involve face-to-face and/or over-the-phone conversation, as well as review and/or handling of correspondence via mail, email or fax.

As part of our partnership with you, we offer education and training for key requirements of the Humana Dual Fully Integrated program, as well as new and existing provider training and information resources on useful industry and Humana-specific topics. **Humana Provider Services** will assist you with ongoing training. Each year, you must complete annual required compliance training and attest that you have done so. You can **access the training and attestation instructions online**.

In addition to the required annual compliance-based training, we offer ongoing education through multiple channels, with options and opportunities for all provider types depending on need and availability. **Humana Provider Services** will work with you to develop customized training programs, which are available online through an e-learning library of more than 300 courses. Topics include business ethics, continuity of care, behavioral health screenings in a primary care setting, self-determination, telehealth, advance directives, working with care coordination teams, SDOH, health equity, quality improvement and value-based payment (VBP). Training and other **information and resources are available online**.

As a Humana provider, you are required to complete all necessary training identified within your contract during your initial Humana orientation. You must also ensure that your affiliated participating providers and staff members are trained on mandatory compliance materials.

Humana and the state of Illinois require all entities that participate with dual Medicare-Medicaid plans—including those contracted with subsidiaries—complete the following training materials:

- Cultural humility, health equity and implicit bias training
- Health, safety and welfare education training
- Medicaid provider training
- Humana orientation training
- Compliance and fraud, waste and abuse training.

Training is available through **Availity Essentials**.

1. Once signed in to **Availity Essentials**, select Payer Spaces > Humana > Humana Learning Center.
2. Select the category: Compliance trainings.
3. Search for the current year training by state (for any states in which you are contracted).

If you have not yet registered on **Availity Essentials**, **this document will guide you through the process to register and get started with Availity Essentials.**

Social Determinants of Health (SDOH)

For information about SDOH, access the following resources:

- **Addressing Social Determinants of Health (SDOH) Physician Quick Guide (opens in new window)**
- **Food Insecurity SDOH Physician Quick Guide (opens in new window)**
- **Loneliness and Social Isolation SDOH Physician Quick Guide (opens in new window)**
- **Transportation SDOH Physician Quick Guide (opens in new window)**

Additional education and training are available to you on our **Illinois provider website** and through our CE program for medical and nonmedical network providers via Relias—a web-based CE library. With more than 300 modules to choose from and over 500 hours of CE credits available, the training modules in Relias provide integrated information to support comprehensive care and address unique member needs. Relias offers courses designed to help you succeed in the emerging value-based healthcare delivery system.

We have also created a resource guide to support physicians, clinicians and care teams to screen and address member social health needs. This resource guide is available to network providers on the **compliance training section of the Illinois provider website**, and is designed to support network providers to:

- Understand the impacts of unmet health needs
- Screen members using evidence-based screening tools

- Support the discussion of SDOH with members and provide member-specific resources and support
- Offer guidance for documentation and coding to monitor and follow up with members needing resource referral, ultimately leading to improved health outcomes

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.

Provider orientation

All new providers will receive Humana's provider orientation. **Humana Provider Services** is available to provide an initial orientation within the timeline of completion of the credentialing process. This orientation reviews our policies and procedures. These personalized meetings are scheduled at your convenience and can include staff you would like to attend. Additional educational training can be scheduled any time by contacting **Humana Provider Services**.

Chapter 5: Member health, safety and welfare

Contact information pertaining to member health, safety and welfare

Contact name	Contact information	Hours of operation
DHS Office of the Inspector General	Phone: 800-368-1463 Website: IDHS Report Fraud, Abuse or Neglect website	24 hours a day, 7 days a week
Illinois Department of Child and Family Services	Phone: 800-25ABUSE (800-252-2873), TTY: 800-358-5117 Website: Illinois DCFS Supporting Illinois Children and Families website	24 hours a day, 7 days a week
Illinois Department of Public Health (IDPH) Central Complaint Registry Hotline	Phone: 800-252-4343, TTY: 800-547-0466 Website: File a Health Care Complaint website	Monday through Friday, 8:30 a.m. to 4:30 p.m., Central time
Illinois Department on Aging, Adult Protective Services Hotline	Phone: 866-800-1409, TTY 711 Website: Illinois Department on Aging Adult Protective Services website	24 hours a day, 7 days a week
Illinois Domestic Violence Victim Services Hotline	Phone: 877-TO-END DV (877-863-6338), TTY: 877-863-6339 Website: Domestic Violence Prevention and Intervention website	24 hours a day, 7 days a week

Contact name	Contact information	Hours of operation
Illinois Healthcare and Family Services Health Benefits Hotline	Phone: 800-226-0768	Monday through Friday, 8 a.m. to 4:45 p.m., Central time
Illinois Helpline for Opioids and Other Substances	Phone: 833-2FINDHELP (833-234-6343) Website: Illinois Helpline website	24 hours a day, 7 days a week
Report Medicaid or Cash Program Fraud Hotline	Phone: 844-ILFRAUD (844-453-7283) Website: Illinois HFS report fraud website	
National Human Trafficking Hotline	Phone: 888-373-7888 Website: National Human Trafficking Hotline website	24 hours a day, 7 days a week
Suicide and Crisis Lifeline	Phone: 988 Website: 988 Lifeline	

Providers are expected to protect the health and welfare of all members and to address identified issues related to quality of care and quality of service. 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.

Compliance with 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 C.F.R. Part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. 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.

Critical incidents

A critical incident is any actual or alleged abuse, neglect or exploitation or any incident that has the potential to place a member or member's services at risk, including those that do not rise to the level of abuse, neglect or exploitation. It also includes any incident that jeopardizes the health, safety and

welfare of a member. This includes events that may cause substantial or serious harm to the physical or mental health of a member or the safety of a member's services.

You are expected to work with care management to resolve all identified critical incidents involving our members in a timely manner and support the safety and well-being of our members.

Reporting

If you determine a member meets the criteria for a critical incident, the critical incident must be reported immediately to the member's Humana care manager. Critical incidents may also include occurrences involving abuse, neglect or exploitation. By law, providers must immediately report suspected abuse, neglect or exploitation risks to the appropriate state agency and the member's Humana care manager.

Reportable conditions

- 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

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

Abuse, neglect and exploitation

Incidents involving abuse, neglect or exploitation need to be reported to Humana and to the appropriate state agency. These types of incidents include but are not limited to:

Term	Definition
Abandonment	Abandonment is the desertion or willful forsaking of an eligible adult by an individual responsible for the care and custody of that eligible adult when a reasonable person would continue to provide care and custody.
Abuse	Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. • Physical: Nonaccidental use of force that results in bodily injury, pain or impairment; includes but not limited to being slapped, burned, cut, bruised or improperly physically restrained • Verbal/emotional: Includes but is not limited to name calling, intimidation, yelling and swearing; may also include ridicule, coercion, and threats • Sexual: Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities

Term	Definition
Confinement	Confinement includes restraining or isolating, without legal authority, an eligible adult for other than medical reasons, as ordered by a physician
Exploitation	Exploitation is the illegal use of assets or resources of an adult with disabilities. It includes, but is not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion or in any manner contrary to law.
Fraud	Fraud means executing or attempting to execute a scheme or ploy to defraud the Humana Dual Fully Integrated program, or obtaining information by means of false pretenses, deception or misrepresentation in order to receive services from Medicaid. Theft of member property by a provider, as well as theft of provider property by a member is included in this definition.
Neglect	Neglect is defined as the failure of another individual to provide an adult with disabilities with, or the willful withholding from an adult with disabilities of the necessities of life including but not limited to food, clothing, shelter or medical care. • Self-neglect: An individual neglects to attend to the individual's basic needs, such as personal hygiene, appropriate clothing, feeding or tending appropriately to medical conditions. • Passive neglect: Another individual fails to provide an eligible adult with the necessities of life including, but not limited to, food, clothing, shelter or medical care because of failure to understand the eligible adult's needs, lack of awareness of services to help meet needs or a lack of capacity to care for the eligible adult. • Willful deprivation: An individual deliberately denies medications, medical care, shelter, food, therapeutic devices or other physical assistance to a person who, because of age, health or disability, requires such assistance and thereby exposes that person to the risk of physical, mental or emotional harm because of such denial; except with respect to medical care or treatment when the dependent person has expressed an intent to forego such medical care or treatment and has the capacity to understand the consequences.
Restraint	Restraint includes any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely.
Seclusion	Seclusion is defined as placing a person in a locked or barricaded area that prevents contact with others.

Additional critical incidents

Events that do not rise to the level of abuse, neglect or exploitation but should still be reported to Humana include but are not limited to:

Term	Definition
Behavioral health incident	A serious behavioral health incident that results in emergency treatment must be reported. This can include self-neglect, self-injury, property damage, verbal aggression, suicide ideation, attempted suicide, sexually problematic behavior, uncontrolled problematic alcohol or substance abuse and any other mental health emergency.
Death, other party	This involves a death that results in a significant event for member. For example, member's caregiver dies in the process of giving the member a bath, thereby leaving the member stranded in the home without care for several days. Passing of immediate family members is not necessary to report unless the passing creates a resulting turn of events that are harmful to the member.
Environmental/unsafe housing/displacement	Unsafe housing is any home or living space which does not provide a safe and healthy environment (e.g., loss of utilities, structurally unsafe). Displacement is the removal of the client from a home or living space due to natural disaster (e.g., fire, flooding, tornado) or eviction. Social environment hazards are the culture that the member lives in and the people and institutions with whom the member interacts, including family, roommates, facility staff and providers.
Legal/criminal activity	Legal/criminal activity should be reported to Humana in an instance where an arrest, charge or conviction has a risk or potential risk upon the member's health and safety, will be reported, and involves state, local or municipal law enforcement. This includes problematic possession or use of a weapon, an arrest, property damage greater than \$50 or other criminal activity including: • Any illegal activity that is allegedly committed by the member in which there is law enforcement involvement. Examples include, but are not limited to: – Arrests – Incarceration – Criminal court appearances/charges – Illegal drug use – Shoplifting • Violation of probation or parole that potentially results in the revocation of probation/parole • Any criminal offense that is committed by a member that results in immediate incarceration

Term	Definition
Medical emergency	A reportable medical emergency is one where admission of a member to a hospital or the provision of emergency medical services (treatment by EMS) results in medical care which is unanticipated and/or unscheduled for the member and which would not routinely be provided by a PCP.
Medication management	This results when there is a discrepancy between what a physician prescribes and what a member takes, such as a member taking the wrong medication, which includes taking medication after it has been discontinued, or a member taking the incorrect medication because it was improperly labeled. Medical management includes situations of a member taking the wrong dose of medication, a member omitting and not taking a prescribed dose of medication within the 24-hour period of a calendar day or a member's refusal to take prescribed medication. It also refers to issues with medication dosage, scheduling, timing, set-up, compliance, and administration or monitoring which results in harm or an adverse effect which necessitates medical care. Any instance of missing medication (e.g., stolen medication) should also be reported here.
Missing person/ elopement	Member is missing or whereabouts are unknown for provision of services.
Significant medical event	A significant medical event is a recent event or new diagnosis that has the potential to impact the member's health or safety. This includes: • Any recurring injury or illness that requires treatment beyond first aid which includes lacerations requiring stitches or staples, fractures, dislocations, loss of limb, serious burns, skin wounds, pneumonia, urinary tract infections, etc. • An injury or illness requiring immediate emergency medical treatment to preserve life or limb • An emergency medical treatment that results in admission to the hospital
Suspicious/ unanticipated death	Criteria for reporting deaths of an unusual nature include, but are not limited to medical treatment error; medication or omission of medication; poor medical care; accidental death; death resulting from suicide; a recent allegation of abuse, neglect or exploitation; or that member was receiving home health services at time of passing. This also includes any death of a member occurring within 14 calendar days of discharge or transfer from a residential program or facility or within 24 hours of discharge or transfer from a residential program or facility, at an agency or facility or at any Illinois Department of Healthcare and Family Services-funded site.

Helpful resources for critical incidents and adverse events

For children younger than 18, contact the **Illinois Department of Child and Family Services**. More information is available on the **Illinois DCFS Supporting Illinois Children and Families website**.

For members with disabilities age 18 and older and seniors living in the community, or if the abuse, neglect or exploitation occurs in the community to a member living in a licensed facility, contact the **Illinois Department on Aging, Adult Protective Services**. More information is available on the **Illinois Department on Aging Adult Protective Services website** as well.

For members in nursing facilities, contact the **Illinois Department of Public Health's Central Complaint Registry Hotline**. More information is available on the **File a Health Care Complaint website**.

For members ages 18 to 59 receiving mental health or developmental disability services in DHS-operated, -licensed, -certified or -funded programs, contact the **DHS Office of the Inspector General**. More information is also available on the **IDHS Report Fraud, Abuse or Neglect website**.

For members in supportive living facilities, contact the **Illinois Healthcare and Family Services Health Benefits Hotline**.

Domestic violence incidents can be addressed through the **Illinois Domestic Violence Victim Services** hotline. Visit the **Domestic Violence Prevention and Intervention website** for more information.

Medicaid program fraud can be reported to the **Medicaid Fraud Hotline** or via the **report fraud website**.

Members in crisis should be referred to the **Suicide and Crisis Lifeline**. More information is available on the **988 Lifeline website**.

Human trafficking concerns can be directed to the **National Human Trafficking Hotline**. More information is available on the **National Human Trafficking Hotline website**.

Chapter 6: Cultural humility, health equity and implicit bias

Contact information pertaining to cultural humility, health equity and implicit bias and interpreter services

Contact name	Contact information	Hours of operation
Humana Concierge Service for Accessibility	Phone: 877-320-2233 Website: Accessibility Resources on Humana.com	Monday through Friday, 7 a.m. to 7 p.m., Central time
Humana Provider Services	Phone: 800-787-3311 (TTY: 711)	Monday through Friday, 7 a.m. to 7 p.m., Central time

Cultural competency

Humana recognizes cultural differences and the influence that race, ethnicity, language and socioeconomic status have on the healthcare experience and health outcomes. We are committed to developing strategies that eliminate health disparities and address opportunities for better care.

Communication is paramount in delivering effective care. Mutual understanding may be difficult during cross-cultural interaction between members and providers. Some disparities may be attributed to miscommunication between providers and members, language barriers, cultural norms, and beliefs and attitudes that determine healthcare-seeking behaviors. Providers can address racial and ethnic gaps in healthcare with an awareness of cultural needs and improvement in communication with a growing number of diverse members.

Cultural competency refers to a set of interpersonal skills that promote the delivery of services in a culturally competent manner to all Medicaid managed care members—including those with limited English proficiency and diverse cultural and ethnic backgrounds—allowing for individuals to increase their understanding, appreciation, acceptance and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Medicaid managed care members.¹⁰

¹⁰ 42 C.F.R. § 438.206

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 also is an important aspect of cross-culture healthcare.

Participating providers are expected to provide services in a culturally competent manner that includes removing all language barriers to service and accommodating the special needs of the ethnic, cultural and social circumstances of the member. Participating providers also must meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care.¹¹

Cultural competence in a hospital or care system produces numerous benefits for the organization, members and community. Organizations that are culturally competent have improved health outcomes, increased respect and mutual understanding from members, and increased participation from the local community. Additionally, organizations that are culturally competent may have lower costs and fewer care disparities.

Providers striving to deliver high-quality care to all members understand that cultural factors influence members' health beliefs, behaviors and responses to medical issues. This section provides guidance for how to consider cultural differences as you build effective relationships with your members during shared decision making.

Racial and ethnic disparities in health and healthcare are well documented. The COVID-19 pandemic highlighted these inequities, which are rooted in structural and systemic racism. Data across 64 measures show significant differences in health outcomes and access to care between people of color and White individuals¹². The Commonwealth Fund 2024 State Health Disparities Report found that Black members received worse care than White members on 52% of quality measures in 2023.¹³

We offer several initiatives to deliver services to all members regardless of ethnicity, socioeconomic status, culture or primary language, including language assistance services, race and ethnicity data collection and analysis, internal staff training, and resources offered in Spanish. Other initiatives provide you with additional resources and materials including tools from health-related organizations that support awareness of gaps in care and information on culturally competent care.

11 Title VI of the Civil Rights Act of 1964; Age Discrimination Act of 1975; Americans with Disabilities Act (ADA); Rehabilitation Act of 1973

12 Ndugga, N., Hill, L., & Artiga, S. (2024, June 11). Key data on health and health care by race and ethnicity. Kaiser Family Foundation. <https://www.kff.org/key-data-on-health-and-health-care-by-race-and-ethnicity/?entry=executive-summary-introduction>

13 Radley, D. C., Shah, A., Collins, S. R., Powe, N. R., Zephyrin, L. C. (2024, April 18). Advancing racial equity in U.S. health care. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/fund-reports/2024/apr/advancing-racial-equity-us-health-care>

Learn how to interact with diverse members

- Keep an open mind. Remember that each member has a unique set of beliefs and values, and members may not share yours.
- Ask members about their beliefs regarding their health condition (e.g., “What do you think caused the problem? What do you fear most about the sickness? Why do you think it started when it did?”). This information will allow you to make the most of your interactions during shared decision making. Recognize and understand that the meaning or value of health prevention, intervention and treatment may vary greatly among cultures, specifically for behavioral health.
- Attend cultural competence training at your organization, through Humana’s cultural competency training offerings or through a continuing education program.
- Be aware of your own culture and how that may affect how you communicate with your members.
- Reach out to cultural brokers to help you learn more about the differences and similarities between cultures. They can tell you how to better address the members you serve regarding cultural appropriateness, beliefs about health and barriers in communication. Cultural brokers might include healthcare and social service workers and cultural group leaders. Ask them to suggest resources you can use to learn more about your members’ cultures.

Know what you don’t know. You won’t be able to learn about every aspect of every member’s culture. Don’t be afraid to let your members know that you are unfamiliar with their culture. Invite them to explain what is important to them and how getting and staying well works in their community.

Keep in mind that culture is not homogenous. There is great diversity among individuals—even in the smallest cultural group. Remember, culture changes over time, especially when one cultural group is exposed to and influenced by another culture.

Provide culturally appropriate decision aids

Ask your members about their learning preferences so you can present information better during shared decision making. Find out if your members prefer for you to offer materials in print, video or audio format. Ask your members if they would like you to explain by talking, using a model, making a drawing or demonstrating how to do something. You may find your members want you to present information in a variety of ways.

Make sure that multimedia decision aids (e.g., videos, DVDs, CDs, audiotapes), other health resources for treatment and other intervention materials reflect the cultures of the members you serve.

When possible, offer decision aids, treatment summaries and educational materials that have culturally relevant descriptions of risks and benefits of treatment options. The best decision aids meet cultural and health literacy or plain language standards.

Health literacy

Health literacy describes a member’s ability to obtain, process and understand basic health information and services needed to make appropriate decisions. Some 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 hospitalization and poor health outcomes

Humana develops member communications based on health literacy and plain language standards.¹⁴ The reading ease of Humana's 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 summarize 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 background: 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.

¹⁴ Plain Writing Act of 2010

- **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.

Implicit bias

Implicit bias, a phrase that is not unique to healthcare, refers to the unconscious prejudice individuals might feel about another thing, group or person.

In healthcare, implicit bias can shape the way medical providers interact with members. Because everyone is susceptible to implicit bias, even clinicians, unconscious preconceptions will naturally seep into member-provider communication.

As with any interaction, implicit bias can have adverse effects on the member experience. By damaging member-provider interactions, implicit bias can adversely impact health outcomes.

In many situations, members notice a provider's implicit bias, and members often report a poor experience as a result. Naturally, a member who notices a provider's implicit bias may feel less inclined to engage deeply with care.

Eliminating implicit bias is a challenging task, because as the experts at Ohio State University's Kirwan Institute said, one's own implicit bias is not something most people are aware of¹⁵. Implicit bias is not purposeful—purposeful discrimination is referred to as explicit.

A strong education campaign can be a good first step in helping clinicians notice their own biases. The process of identifying and acknowledging implicit bias in healthcare is only in its infancy. As more organizations commit to ending racial health disparities and working toward health equity, this will be an important step toward that end.

¹⁵ Breaking Bias: Lessons from the OSU Implicit Bias Module. The Ohio State University. Retrieved June 11, 2024, from <https://u.osu.edu/breakingbias/>

Actions healthcare providers can take to combat implicit bias include the following:

- Have a basic understanding of the cultures from which your members come.
- Avoid stereotyping your members; individuate them.
- Understand and respect the magnitude of unconscious bias.
- Recognize situations that magnify stereotyping and bias.
- Know the national standards for culturally and linguistically appropriate services (CLAS) in health and healthcare (see the **Think Cultural Health website**).
- Perform “teach back” (e.g., the National Patient Safety Foundation’s Ask Me 3® educational program).
- Assiduously practice evidence-based medicine.
- Use techniques to debias member care, including training (including cultural competency training offered through Humana), intergroup contact, perspective-taking, emotional expression and counter-stereotypical exemplars.

Cultural humility

Cultural humility means admitting what we do not know about patients and being willing to learn from their experiences, while also being aware of our own embedded cultural beliefs.¹⁶ Cultural humility in healthcare looks like self-reflexivity and assessment, appreciation of patients’ expertise in the social and cultural context of their lives, openness to establishing power-balanced relationships with patients, and a lifelong dedication to learning.¹⁷

Balancing power and privilege means:^{18, 19}

- Advocating to address power and privilege within healthcare institutions and doing the individual work needed to overcome them
- Recognizing patients bring valuable insight and knowledge to the equation of their medical care
 - Multiple studies show there is increased mistrust and unequal treatment in vulnerable communities.
- Realizing medical systems hold scientific knowledge and power, while patients hold power in personal history and preferences along with the cultural context of expressing these

Institutional accountability means:

- Examining the relationships organizations have with the communities they serve

16 Lekas, H-M., Pahl, K., & Lewis, C. F. (2020). Rethinking cultural competence: Shifting to cultural humility. *Health Services Insights*, 13(1-4). <https://doi.org/10.1177/1178632920970580>

17 Ibid.

18 Bailey, Z. D., Feldman, J. M., & Basset, M. T. (2020). How structural racism works – racist policies as a root cause of U.S. racial health inequities. *The New England Journal of Medicine*, 384(5), 768-773.

<https://doi.org/10.1056/NEJMms2025396>

19 Office of Health Equity. Min

- Making space for evolving knowledge about a cultural community and developing trusting relationships within the context of their beliefs and values
- Ensuring efforts are a top priority amongst leaders at the organization and understanding cultural humility is an active journey

Lifelong learning and self-reflection means:

- Continually being curious and open learning from patients, families and communities, which is necessary for growth
- Learning from patients, who are the experts and authorities in their own lives
- Examining one's own bias, beliefs and assumptions, which is critical as we continue our lifelong learning

Health equity

Health equity is the elimination of unjust, avoidable and unnecessary barriers in health and healthcare. According to the AHA Institute for Diversity and Health Equity, health equity ensures that every individual has a fair and just chance to attain their best possible health.²⁰ Health barriers can be based on background, where someone lives, the resources they have or systemic factors such as racism and discrimination. The concept of health equity suggests everyone should have a fair opportunity to attain their full health potential and no one should be disadvantaged from achieving it.

Factors affecting health equity

SDOH are the conditions in the places people live, learn, work, play and worship that can negatively affect health outcomes. Long-standing inequities in 6 key areas influence a wide range of health and quality-of-life risks and outcomes.²¹ Examining these health and social inequities can help us better understand how to promote health equity and improve health outcomes.

Key areas include:

- Social and community context: This includes a patient's interactions with the places they live, work, learn, play and worship and their relationships with family, friends, coworkers, community members and institutions. This also includes discrimination and racism.
- Healthcare access and use: People with disabilities, people from some racial and ethnic minority groups, people from rural areas, and populations with lower incomes are more likely to face multiple barriers to accessing healthcare.
- Neighborhood and physical environment: This includes crime, lack of access to healthy food, lack of safe and affordable housing, lack of public transportation, and limited infrastructure and resources.

²⁰ AHA Institute for Diversity and Health Equity. (2024). Glossary of health equity terms.

<https://equity.aha.org/glossary>

²¹ Healthy People 2030. (2023). Social determinants of health. Office of Disease Prevention and Health Promotion. <https://health.gov/healthypeople/priority-areas/social-determinants-health>

- Poor quality or dangerous workplace conditions: Some people may face exposure to elements that can have negative impacts on their health in their workplace, such as secondhand smoke or loud noises.
- Education level: People who are historically marginalized, such as people from racial and ethnic minority groups, people with disabilities, and populations with lower incomes, are disproportionately affected by inequities in access to high-quality education.
- Income and wealth gaps: Individuals from some racial and ethnic minority groups and other historically marginalized groups also face greater challenges in getting higher paying jobs with good benefits due to less access to high-quality education, geographic location, language differences, discrimination and transportation barriers.

Linguistic services

Humana offers several initiatives to deliver services to all members regardless of ethnicity, socioeconomic status, culture and primary language. These include:

- Language assistance services
- Race and ethnicity data collection and analysis
- Internal staff training on cultural humility, health equity, health literacy and implicit bias
- Print resources available in both English and Spanish
 - You or the member can request written materials in languages other than English by calling **Humana Provider Services**.

Our care managers and service coordinators are assigned to members based on their language needs, cultural compatibility and gender preference, to better align with the individual's choice.

All Illinois clinical workers, community health workers and health equity associates complete cultural humility/implicit bias training.

Recognizing that complete and accurate provider data is foundational to ensuring an adequate and responsive network, we have an annual provider education campaign encouraging our network to self-report language, race and ethnicity data. The campaign educates providers on how we use this data to ensure culturally competent and equitable care. We seek to collaborate with other selected MCEs on this campaign to promote system-wide accessibility for this important data.

Any change in a provider's name, address, telephone number or change of ownership must be reported immediately to **Humana Provider Services** online via **Availity Essentials**.

Interpreter services

If you are assisting a member who needs interpretive services, please be aware we provide the following communication services at no cost when the member is interacting with us. You can connect Humana members via the following:

- Over-the-phone interpretation is available in 150 languages at all Humana touchpoints.

- American Sign Language interpreters are available in person or via video—Call **Humana Concierge Services for Accessibility** to schedule at least 48 hours in advance.
- Linguistically trained interpreters are available for visually impaired customers—Call **Humana Concierge Services for Accessibility** to schedule at least 48 hours in advance.
- TTY services: This is voice-to-text capability provided by the federal relay service with no special instructions, and is available at all touchpoints.
- Written materials are available in languages other than English, and in alternative formats including Braille, audio, large print and accessible PDF, can be requested by you or the member by calling **Humana Provider Services**.

Please refer to the **provider responsibilities section of this manual** for more information.

Cultural humility, health equity and implicit bias plan

To request a printed copy of our cultural humility, health equity and implicit bias plan at no charge, please contact Humana Provider Services. You may also review our **cultural humility, health equity and implicit bias training**.

Chapter 7: Covered services

Contact information pertaining to covered services

Contact name	Contact information	Hours of operation
Behavioral Health Crisis Line	Phone: 800-345-9049	24 hours a day, 7 days a week
Crisis and Referral Entry Service (CARES) Hotline	Phone: 800-345-9049 TTY: 866-794-0374	24 hours a day, 7 days a week
Transplant services	Phone: 866-421-5663 Email: transplant@humana.com Fax: 502-508-9300 Website: Transplant services	Monday through Friday, 7 a.m. to 4 p.m., Central time Messages left after hours will receive a response the next business day.
Go365 by Humana	Phone: 866-677-0999	Monday through Friday, 7 a.m. to 6 p.m., Central time
Humana Concierge Service for Accessibility	Phone: 877-320-2233 Website: Accessibility Resources on Humana.com	Monday through Friday, 7 a.m. to 6 p.m., Central time
Humana Provider Services	Phone: 800-787-3311 (TTY: 711)	Monday through Friday, 7 a.m. to 7 p.m., Central time
LTSS Utilization Management Team	Email: HumLTSStransitions@humana.com	

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.

Humana is required to provide medically necessary care with current limitations for the services listed below. Medically necessary services are those utilized in the state Medicaid program, including

quantitative and nonquantitative treatment limits, as indicated in state statutes and regulations, the state plan, and other state policy and procedures. While appropriate and necessary care must be provided, Illinois Humana Dual Fully Integrated is not bound by the current variety of service settings. More detailed information on Illinois Medicaid policy for services and benefits may be found in the corresponding provider reference modules for each service and provider type. These provider reference modules are available electronically on the **Humana Dual Fully Integrated communications and network notices website**.

Out-of-network care for unavailable services

Humana authorizes out-of-network care based on medical necessity when a network provider is not available to provide members with medically necessary covered services in a timely manner. Humana coordinates payment with the out-of-network provider to confirm costs to the member are not greater than they would be if the service were provided in network. Humana also takes into consideration continuity of care and long-term specialized care needs, including oncology and transplant services.

Value-added benefits

Value-added benefits are those offered by Humana and approved in writing by the state and are detailed in this provider manual. 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 will also arrange for specialty, LTSS and behavioral healthcare as necessary.

Care coordination and service authorization

LTSS service authorization is created by the **LTSS Utilization Management Team**. PA requests for PERS must be submitted through the LTSS team by either contacting the member's care coordinator or emailing the **LTSS Utilization Management Team**.

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

Covered medical services

Humana, through its contracted providers, is required to arrange for medically necessary services for each member, detailed as follows.

Benefit summary

Covered plan services (general)

- Advanced practice nurse services
- Ambulatory surgical treatment center services
- Assistive/augmentative communication devices
- Audiology services
- Blood, blood components and the administration thereof
- Chiropractic services
- Dental services, including oral surgeons
- Family planning services and supplies
- FQHCs, RHCs and other encounter rate clinic visits
- Home health agency visits
- Hospital emergency room visits
- Hospital IP services
- Hospital ambulatory services
- Laboratory and x-ray services
- Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies
- Mental health services
- Nursing care
- Nursing facility services
- Optical services and supplies
- Optometrist services
- Palliative and hospice services
- Pharmacy services
- Podiatric services
- Post-stabilization services
- Renal dialysis services
- Respiratory equipment and supplies
- Services to prevent illness and promote health

- Subacute alcoholism and substance abuse services
- Transplants
- Transportation to secure covered services

Excluded services

Excluded benefits are defined as services not covered by Humana, 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 provided in a state facility operated as a psychiatric hospital as a result of a forensic commitment
- Services provided through an LEA
- Services that are experimental or investigational in nature
- Services provided by a nonaffiliated provider and not authorized by Humana, unless the contract between Illinois and Humana specifically requires that such services be covered services
- Services provided without required referral or PA as set forth in this provider manual
- Medical and surgical services provided solely for cosmetic purposes
- Services or items furnished for the purpose of causing, or for the purpose of assisting in causing, the death of a member, such as by assisted suicide, euthanasia or mercy killing, except as otherwise permitted²²

Services for which Humana uses any portion of a capitation payment to fund roads, bridges, stadiums or any other items or services that are not covered services, except such items or services that are emergency services or included as additional covered services

Members who believe an excluded service should be covered can file an appeal. For information about filing an appeal, please refer to the **[grievances and appeals section of this provider manual](#)**.

Value-added benefits

Humana Dual Fully Integrated offers members extra benefits, tools and services at no cost to the member that are not otherwise covered or that exceed limits outlined by the Illinois state plan and the Illinois Medicaid fee schedules. These added benefits are more than the amount, duration and scope of covered services listed in this manual.

In instances where an enhanced service is also a Medicaid-covered service, Humana administers the benefit in accordance with all applicable service standards pursuant to our contract, the Illinois Medicaid state plan and all Medicaid coverage and limitations handbooks. Humana members have specific value-added benefits:

²² P. L. 105-12, § 3(b), incorporated by § 1903(i)(16) of the SSA

Enhanced services	Details and limitations
Fall prevention kit	Members at risk for falls may receive a fall prevention kit once per lifetime. The kit contains: • Nonslip socks • Reacher/grabber • Bathmat • Stair treads The member must not reside in residential facility or nursing facility. Care coordinator approval is required.
Nonmedical transportation	Members may receive up to 15 round trips or 30 one-way trips, up to 30 miles each trip, for nonmedical transportation per year to locations such as social support groups, wellness classes, WIC and SNAP appointments, and food banks. This benefit also offers transportation to locations providing social benefits and community integration for members such as community and neighborhood centers, parks, recreation areas, and churches. Nonwaiver members must reside in a home and/or community-based setting
Transition assistance into community living	All members moving from a nursing facility to their own home may receive up to \$5,000 per lifetime. • Assistance is for paying with security and utility deposits, household furnishings/supplies, and moving expenses. • Member must be moving out of a nursing facility into the member's own home where they are responsible for their own living expenses. Care coordinator approval is required.
Personal care attendant services	Members not covered by an HCBS waiver may receive up to 20 hours of personal care attendant services per year. A 4-hour minimum is required per use. Care manager approval is required.
Smartphone	Smartphones can provide easy access to health-related information and enable members to stay connected to their care team and health plan. Humana members who qualify for the Federal Lifeline program are eligible to receive a free smartphone with monthly talk minutes, text and data.

Go365by Humana

Go365 [by Humana]® is a learning and living program available to our [FIDE-SNP] members. Go365 rewards members for completing healthy activities, including getting preventive screenings, staying active and participating in community events. Rewards can be redeemed for gift cards in the Go365 Mall to help with everyday living expenses and other well-being related purchases. As part of the program, members also have access to our robust libraries of expert-led online courses and podcasts on topics such as nutrition and cooking, heart health, diabetes management and on-demand fitness classes.*

* Humana publishes billing guidelines online for these benefits/services.

How to earn rewards and get started

1. Members complete eligible healthy activities like walking or getting an annual wellness visit.
2. Members earn rewards they can redeem for gift cards.
3. Once they have earned at least \$10 in rewards, members choose gift cards in the Go365 Mall on Go365.com.

Members with a MyHumana account can use the same information to sign in to Go365.com. If an account is not currently set up, they can activate their profile at MyHumana.com. Once signed in to Go365, they'll see eligible activities they can complete to earn rewards and details on how to track their actions.

View the chart below for a list of rewards. Please note: Activity categories and reward values are subject to change.

Area	Activity	Reward
Prevention	HRA	\$10
	Flu vaccination	\$5
	Annual Wellness Visit	\$25
	Mammogram	\$30
	Colorectal screening	\$50
	Diabetic bundle (complete all 4 screenings for reward)	\$40
	• Kidney urine test	
	• Kidney blood test	
	• Hemoglobin A1C (HbA1c) test	
	• Diabetic eye exam	
Health education and mental well-being	Bone density	\$20
	Blood pressure tracking (once per year)	\$5
	Complete medication adherence barriers survey	\$10
	1. Enroll and onboard for new members and returning members who register online for the first time	\$10
	2. Update and/or confirm communication preferences in Go365 for existing members	
	3. Social and health education (attend a health education or art class, participate in an athletic event, social club, or religious gathering or event)	
	4. Mental health survey/assessment/ memory screener†	
Exercise and fitness	1. Connect a device and/or complete first workout.	\$60
	2. Member personalizes fitness journey on Go365.com.	
	Complete minimum of 12 workouts per month, tracked via SilverSneakers®, fitness device, online or paper-based tracker (minimum of 5000 steps per day). Other physical activities may include golfing, swimming, Zumba, yoga, strength training, etc. Available to members with SilverSneakers® included on their plan.	

† Activity categories and reward values are subject to change. If members have questions, they can call **Go365**.

Reward amounts shown represent the value of the reward, not actual dollars. Rewards have no cash value and must be earned and redeemed within the same program year. Any rewards not redeemed by the end of the program year will expire. Gift cards and denominations are subject to change at any time without notice.

Copays/coinsurance/member cost-sharing requirements

State requirements and federal regulations prohibit providers from billing Humana members for medically necessary covered services except under extremely limited circumstances. Please refer to the **member billing section of this manual** for more information.

Humana Dual Fully Integrated members may be required to pay a monthly patient liability. Patient liability is the amount of a member's income, as determined by the state, to be collected each month to help pay for the member's nursing facility stay. Patient liability applies to members who are determined to meet NFLOC and receive institutional LTSS.

Emergency services

Medical

Humana 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.

Humana members should go to the closest ER or any other emergency setting if they have any of the following:

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

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

If the ER physician treating the member determines the visit is not an emergency, the member will be given the choice to stay and receive medical treatment or follow up with their PCP.

If the member's PCP responds to the hospital's notification, and the hospital physician and the PCP discuss the appropriate care and treatment of the member, the managed care plan may have a

member of the hospital staff with whom it has a participating provider contract participate in the treatment of the member within the scope of your hospital staff privileges.

If the member is treated for an emergency and the treating doctor recommends treatment after the member is stabilized, the member is instructed to contact their Humana PCP.

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

Behavioral

For behavioral health services, please instruct members to call the Behavioral Health Crisis Line.

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

Please refer to the **behavioral health chapter of this provider manual** for more details.

Telehealth services

Humana reimburses providers for telehealth services, which refers to services provided by using interactive telecommunications equipment that includes, at a minimum, audio equipment permitting two-way communication between a member and provider. Telehealth is defined as the practice of healthcare delivery by a provider who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis or treatment. This applies to any person or entity prescribing or reviewing a request for Illinois Medicaid services and to all providers of Illinois Medicaid services that are enrolled in or registered with the Illinois Medicaid program.

Humana will not reimburse the following:

- Chart reviews
- Email messages
- Facsimile transmissions
- Equipment required to provide telemedicine services You must include modifier GT on the CMS-1500 claim form.

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

If you are approved by Humana to provide services through telehealth, you must implement telehealth fraud and abuse protocols to prevent fraud and abuse that address:

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

Providers offering these services to members with Medicaid coverage must address each of the following requirements:

- Telecommunication equipment and telehealth operations meet the technical safeguards required,²³ where applicable.
- Administration of telehealth services complies with HIPAA and other state and federal laws pertaining to member privacy.
- Telehealth services provided are documented in the member's medical/case record.
- Telehealth services are offered to the member as a choice of whether to access services through face-to-face or telehealth encounters. This must be documented in the member's medical/case records.
- Telehealth services must be performed by licensed practitioners within the scope of their practice.

Note: Humana does not reimburse for the costs or fees of any of the equipment necessary to provide services through telehealth, including telecommunication equipment and services.

Providers are encouraged to contact **Humana Provider Services** if they offer or plan to offer these services to members covered by Humana.

If your practice is using telehealth with a hearing-impaired member, please call **Humana Concierge Services for Accessibility**. Many telehealth platforms do not allow for an interpreter to participate. If this is the case with your telehealth platform, please call **Humana Concierge Services for Accessibility** to utilize Humana's secure doxy portal with the member, yourself and an interpreter.

Please keep in mind that when using telehealth with a disabled member, nothing can be downloaded to the member's phone.

Transplant services

Medically necessary transplants and related services are covered. PA and other limits may apply.

Family planning

Any provider can provide members with family planning services without PA. Providers should make available and encourage all pregnant members and mothers with infants to receive postpartum

²³ 45 C.F.R. § 164.312

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.

Family planning services should be furnished on a voluntary and confidential basis. Humana provides family planning services to help members make comprehensive and informed decisions about family size and/or spacing of births.

The following services are provided:

- Preliminary physician examinations
- Annual examinations
- Professional services when problems are indicated
- Laboratory tests
- Contraceptive devices, supplies and surgical sterilization procedures

This information should be documented in the member's medical record to meet the contractual requirement. Humana or the state may audit medical records to confirm compliance with this contractual clause.

Members can choose from any Medicaid doctor for family planning services. Prior approval is not required.

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

Chapter 8: Behavioral health

Contact information pertaining to behavioral health

Contact name	Contact information	Hours of operation
Automated member eligibility verification system	Phone: 855-481-7044	24 hours a day, 7 days a week
Behavioral Health Crisis Line	Phone: 800-345-9049	24 hours a day, 7 days a week
Carelon Health Options	Mail: Carelon Health Options Appeals Department P.O. Box 1856 Hicksville, NY 11802-1856	
Carelon IVR line	Phone: 855-481-7044	24 hours a day, 7 days a week
Carelon PA requests	Phone: 800-397-1630	24 hours a day, 7 days a week
Carelon Provider Disputes	Fax: 305-722-3013	
Carelon Provider Services	Phone: 800-397-1630 Email: provider.relations.IL@carelon.com	Monday through Friday, 7 a.m. to 7 p.m., Central time
EDI support	Email: e-support.services@beaconhealthoptions.com	
Humana Provider Services	Phone: 800-787-3311 (TTY: 711)	Monday through Friday, 7 a.m. to 7 p.m., Central time
PQOC team	Email: CorporatePQOC@carelon.com Fax: 855-677-7672	

Contact name	Contact information	Hours of operation
Woburn Claim Appeals	Email: WoburnClaimAppeals@carelon.com	
Crisis and Referral Entry Service (CARES) Hotline	Phone: 800-345-9049 TTY: 866-794-0374	24 hours a day, 7 days a week

About this chapter

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

Information is also provided on billing transactions. Caredon's level-of-care criteria (LOCC) are accessible by contacting **Caredon level-of-care criteria**.

The manual is published on the **Humana Dual Integrated (HMO D-SNP) in Illinois documents and resources website** and on **Caredon's website**. The provider manual is also available on Caredon's **eServices provider portal** (registration required). Only the eServices publication includes Caredon's LOCC. You may also request a printed copy of the manual by contacting **Caredon level-of-care criteria**.

Manual updates as permitted by the PSA are posted on the Humana and Caredon websites, and notification may also be sent by postal mail and/or email. Caredon 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. Caredon provides 60 days' notice unless the change is mandated sooner by state or federal requirements.

Behavioral health overview

Behavioral health and SUD services are covered services for Humana members. We recognize that behavioral health and physical health function as a part of the whole person, and one can affect the other. Therefore, we use a holistic approach to address behavioral health and substance use.

Humana covers a comprehensive range of behavioral health services, including:

- Outpatient coverage for:
 - Medication management
 - Therapy services, including individual, group and family therapy
 - Care management offered through key providers
- A broad range of services for both behavioral health and SUDs, including:
 - Intensive outpatient

- Partial hospitalization
- Crisis stabilization
- IP or residential treatment based on medical necessity
- Access to community-based resources

Providers, members or other responsible parties can call **behavioral health services** to verify available behavioral health and substance-use benefits and to seek a referral or direction for obtaining behavioral health and substance-use services. The Humana network focuses on improving the health of our members through efforts aimed at increased well-being, using member-centered, evidence-based practices. Our goal is to provide the level of care needed by the member in the least restrictive setting—the right care, at the right time, in the right setting.

For emergency behavioral healthcare within or outside the service area, please instruct members to go to the closest hospital ER or any other recommended emergency setting. Members should contact their PCP first if they are unsure whether they are experiencing an emergency. Emergency behavioral health conditions include:

- The member is a danger to themselves or others.
- The member is unable to carry out actions of daily life due to functional harm.
- The member is experiencing serious harm to the body that may cause death.
- In addition, Humana and the mental health provider shall ensure:
- The member has a follow-up appointment within 7 calendar days of discharge.
- All required prescriptions are authorized at the time of discharge.
- Coordination of care
 - Discharge planning begins upon admission and is designed for early identification of medical and/or psychosocial issues requiring post-hospital intervention.
 - Discharge plans from behavioral health IP admissions will be monitored to ensure they incorporate the member's needs for continuity in existing behavioral health therapeutic relationships.
 - Behavioral health care providers should assign a mental health targeted care manager to oversee the member's care to ensure a smooth transition to a lower level of care.
 - The concurrent review clinician works with the attending provider, hospital discharge planner, family members, guardians, ancillary providers and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the member to the appropriate level of care.
 - An IP review nurse may refer an IP member with identified complex discharge needs to transitional care management for in-facility outreach.

Partnership between Humana and Carelon

Humana partnered with Carelon Health Options LLC (Carelon) to manage the delivery of behavioral health services for our Humana Dual Fully Integrated plan members in Illinois.

Members are eligible to receive comprehensive assessments, care planning and coordination from Humana. For further details, please refer to the **member eligibility and enrollment chapter 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 care. Carelon provides behavioral health management services to 42 million people through partnerships with more than 50 health plan partners in 50 states. Most often colocated 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

Humana's 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 Provider Services**, 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 can be reached via email or by phone by contacting **Carelon Provider Services**.

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 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.

Transactions and communications

Carelon's website contains answers to frequently asked questions, clinical practice guidelines, clinical articles, links to numerous clinical resources and important news for network providers. Providers can also access eServices and EDI through **Carelon's website**.

Email

Carelon encourages providers to communicate with **Carelon Provider Services** via email. 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 accordance 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. It is a HIPAA violation to include any patient-identifying information or PHI except under certain circumstances.

Electronic media

eServices

Through Carelon's **eServices secure provider portal** all provider transactions are supported, which saves time, postage expense, billing fees and paper waste. Access to **eServices provider portal** is free to Humana-contracted Carelon network providers and is always available to you.

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 the **eServices provider portal** 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.

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 Carelon Provider Services.

Interactive voice recognition (IVR)

IVR is available to providers as an alternative to eServices. IVR provides accurate, up-to-date information by telephone and is available for selected transactions. Please call **Carelon's IVR line**.

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, Humana ID and date of birth when verifying eligibility through eServices and through **Carelon's IVR line**.

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**.

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**, then contact **EDI support**. You may also submit any technical or business-related questions to **EDI support**. 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.

Electronic transaction availability

Transaction/capability	eService	Phone	EDI
Access Carelon's LOCC and provider manual	Yes		
Check number of visits available	Yes	Yes	
Download ERA	Yes		
EDI acknowledgment and submission reports	Yes		Yes (HIPAA 837)

Transaction/capability	eService	Phone	EDI
Pend authorization requests for internal approval	Yes		
Print claims reports and graphs	Yes		
Submit claims	Yes		Yes (HIPAA 837)
Submit PA requests	Yes		
Update practice information	Yes		
Upload EDI claims to Carelon and view EDI upload history	Yes		Yes (HIPAA 837)
Verify member eligibility, benefits and copayment	Yes	Yes	
View authorization status	Yes	Yes	
View claims status	Yes	Yes	

Access standards

Humana members may access behavioral health services at any time by contacting the **Behavioral Health Crisis Line**. The **Humana Provider Services** line includes an option for connecting directly to Carelon member services for emergencies or PA 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.

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 calendar days

Access standards for Humana's behavioral health network are established to ensure 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.

Service availability and after-hours accessibility

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

Service availability	Hours of operation
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 through Friday, 9 a.m. to 5 p.m., Central time, at a minimum. Evening and/or weekend hours should also 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 access to competent medical interpretation of all communications with members with LEP and hearing or visual impairments. This includes having available TTY services, sign language and bilingual interpreters to facilitate communication when necessary. Providers must 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 Provider Services**.

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.

Behavioral health provider credentialing and recredentialing

All Illinois providers wanting to participate in the program must be credentialed through IMPACT 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, please contact **Carelon Provider Services**.

Provider training

Please see the **provider training section of this provider manual** for more information.

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 Humana Dual Fully Integrated 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 Humana Dual Fully Integrated 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 an 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 contacting the **automated member eligibility verification system**. 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 the **Carelon IVR line**.

Provider database

Humana and Carelon maintain a provider-reported database of provider information. This database can be found on **Carelon's website**, or a printed copy can be requested by calling the **Carelon IVR line**.

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 to **Carelon Provider Services**.

- 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 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

Adding sites, services and programs

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.

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.

Member benefits and policies

Covered services

Humana covers behavioral health and substance use services via Carelon for members in Illinois. Under the health plan, various 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 PA 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
- IP hospitalization
- Crisis stabilization and observation
- ER services

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

Member rights related to behavioral health

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 Fair 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 provider 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 populations 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, the provider 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 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 on **Carelon's provider website**. You can also refer to **Carelon's provider toolkit** to obtain the form. Alternatively, you may use your own form. If you elect to use your 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 Humana 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 Humana 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 Provider Services**

Providers also can use utilize **Availity Essentials** to verify member eligibility.

Provider portal

Sign in to **Carelon's secure provider portal** 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.

You can also contact the **Carelon IVR line** and utilize the available 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 may also 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 check eligibility frequently.

Behavioral health quality management and improvement

Program description

Carelon administers a QMI program that continually monitors and improves the effectiveness of behavioral health services delivered to members. Carelon's QMI program integrates the principles of 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**.

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 with claim, pharmacy and utilization data.

Carelon welcomes provider comments about the relevance and utility of its guidelines, any improved client outcomes noted because of guideline application and provider experience with any other guidelines. To provide feedback or request paper copies of the Carelon practice guidelines, email **Carelon Provider Services**.

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) 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.

Quality monitoring

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

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 QMI 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 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 contacting the **Carelon IVR line**.

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 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.

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?
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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 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 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 the beginning of a session? • If there was a technical difficulty did the provider document alternate communication and state how the session was continued or rescheduled?

In addition to the 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 law²⁴, 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 **Illinois DPH advance directives website**.

²⁴ Patient Self-determination Act, 42 U.S.C.A. § 1396a[w] [West 1996]

Behavioral health care coordination and communication

Communication between OP BH 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
- Updates at least quarterly during the course of treatment
- 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 PA submitted by the provider and through chart reviews.

Communication between IP/diversionary providers, PCPs and other OP 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
- After-care services for each type, including:
 - Name of provider
 - Date of first appointment
 - Recommended frequency of appointments
 - Treatment plan

IP 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 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 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 BH 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 BH hospitalization

All IP 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 IP 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 after-care 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 Dual Fully 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 contacting **Member Services**. A 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
 - Includes events that result in a significant event for member (e.g., death of caregiver while giving member a bath, leaving a member stranded).
 - Does not include family members if there was no harm to the 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 member
 - 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 individual's 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
 - This includes 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 must be reported.
- 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 must be reported.
- Fire/natural disaster
 - Any event or force of nature that has catastrophic consequences, such as flooding, tornados or fires, must be reported.

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 system for Supportive Living Facilities** webpage 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 incidents and events reportable to Carelon table that follows for more details about reporting incidents and events to Carelon.

Incidents and events reportable to Carelon

Objective	Details
Reporting	Carelon's Clinical department is available 24 hours a day. Providers can contact the Carelon IVR line 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. This form can be sent to the member safety team via fax or email to the PQOC team .
Information to include	All relevant information related to the nature of the incident The parties involved (names and telephone numbers) The member's current condition

Behavioral health care management

Behavioral health 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:

- Ensuring 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 PA 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 ICPs

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 providers 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 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 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 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, some procedures should be used by Humana and Caredon 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 the new behavioral healthcare provider, the PCP and other providers.

Behavioral health 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 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 definition

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**.

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 plan, the denial of a member's request to obtain services outside of the network • (vii) the denial of a 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 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 PA 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.
Postservice 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 IP 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 IP, 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.

Verification of member eligibility

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.

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 PA. 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, the member should follow these procedures:

- 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 **behavioral health crisis hotline**. Qualified mental health professionals are available anytime 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 the member's emergency care. Members should contact **Humana Provider Services**.

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 PA 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 out of network psychiatric facility available, Carelon authorizes boarding the member in a medical unit until an appropriate placement becomes available.

Carelon clinician availability

All Carelon clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures. Carelon clinicians are available 24 hours a day, 7 days a week to receive crisis calls from providers for authorization of IP 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 **PA section of this provider 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 PA, 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 authorization in this way. Authorization decisions are posted on eServices within the decision time frames outlined in the **preservice review, concurrent review, and post-services review tables in this provider manual**. 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 on **Carelon's website under Provider**.

Inpatient services

All IP services, including IP electroconvulsive treatment (ECT), require telephonic PA within 24 hours of admission. Providers should contact **Carelon Provider Services** for all IP 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.

Updated per 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 determination is 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 continues 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 IP 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 the decision and notification time frame tables that follow.

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 table below presents 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.

Note: The maximum time frames may vary from those described in 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 PA requests expire before Carelon makes a decision, an adverse action notice goes out to the member on the date the time frame expires.

Preservice review

	Type of decision	Decision time frame	Verbal notification	Written notification
Initial authorization for other urgent behavioral health services	Urgent	Within 72 hours	Within 72 hours	Within 48 hours
Initial authorization for nonurgent behavioral health services	Standard	Within 14 calendar days	Within 14 calendar days	Within 10 calendar days

Concurrent review

	Type of decision	Decision time frame	Verbal notification	Written notification
Continued authorization for IP 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

	Type of decision	Decision time frame	Verbal notification	Written notification
Authorization for behavioral health services already rendered	Nonurgent/ standard	Within 30 calendar days	Within 30 calendar days	Within 30 calendar days

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 decided within 1 business day. If members, member representatives or providers are not satisfied with the outcome of reconsideration, they may file an appeal.

Outpatient authorization guidelines

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

Behavioral health provider appeals

BH 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 behavioral health provider appeal Claim appeals

You can submit provider disputes by contacting **Carelon Behavioral Health** directly.

Email

Provider claim disputes submitted in writing can be emailed to **Woburn Claim Appeals**.

Fax

Provider claim disputes can be submitted in writing via fax to **Carelon Provider Disputes**.

Provider portal

Provider claim disputes can be submitted in writing online using the **Carelon provider portal**. Select Tools, enter the health plan name then select Claims.

Mail

Please refer to the **Humana claim payment inquiry resolution guide** for more details, and be prepared to provide the following information with your written claim dispute:

- 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.

Submit written provider disputes via mail to **Carelon Health Options**.

Member grievances, appeals and State Fair Hearing requests

Members have the right to file a grievance or appeal. They also have the right to request a State 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

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 circumstances 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 the 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.

837 Companion Guide 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. Please refer to the **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** 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 IP 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.

Provider obligations for Behavioral Health coding, and ADT accuracy

Accurate ADT data is critical to ensure that timely interventions fully support Humana Dual Fully Integrated (HMO D-SNP) members. A complete and reliable clinical picture helps deliver whole person care and reduces avoidable re-admissions. Missing or inaccurate fields create care gaps, especially for behavioral health (BH).

When BH diagnoses are omitted at admission, it eliminates opportunities for timely referrals, risk adjustment and the development of complete clinical histories. Using proper ICD-10 BH codes enables immediate care interventions.

Providers are responsible for:

- Coding to the highest level of specificity for the ICD 10 when it is a BH diagnosis.
- Reviewing documentation to ensure coding aligns with the clinical record.
- Updating codes promptly when a diagnosis changes.
- Ensuring coding staff are trained on current ICD-10 updates, especially for BH.
- Utilizing available Resources to use when entering ICD-10 BH codes into the ADT platform.

For more information, please see the **Illinois HealthChoice ADT website** and the ICD-10-CM Codes List.

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 following table lists some HIPAA-compliant modifiers accepted by Carelon.

HIPAA modifier	Modifier description
AH	Clinical psychologist
AJ	Clinical social worker
HB	Adult program, non-geriatric
HC	Adult program, geriatric
HD	Pregnant/parenting women's program
HF	Substance use program
HG	Opioid addiction treatment program
HH	Integrated behavioral health/substance use program
HI	Integrated behavioral health/developmental disabilities program
HK	Specialized behavioral health programs for high-risk populations
HM	Less than bachelor's degree level
HN	Bachelor's degree level
HO	Master's degree level
HP	Doctoral level
HQ	Group setting
HR	Family/couple with client present
HS	Family/couple without client present
HU	Funded by child welfare agency
HW	Funded by state behavioral health agency
HX	Funded by county/local agency
SE	State and/or federally funded programs/services
TD	Registered nurse
TF	Intermediate level of care
TG	Complex/high level of care
TJ	Program group, child and/or adolescent
U3	Psychology intern
U4	Social work intern
U6	Psychiatrist ^{*25}
UD	Substance use service
UK	Service provided on behalf of the client to someone other than the client-collateral relationship

25 *This modifier is required when billing for 90862 provided by a psychiatrist.

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 the claim transaction overview table that follows.

Coordination of benefits (COB) for behavioral health

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 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

1. A quarterly approval report is generated that lists the percentage of claims paid in relation to the volume of claims submitted.
2. All providers below 75% approval rate have an additional report generated listing their most common denials and the percentage of claims they reflect.
3. 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:

- **Carelon's provider portal**
- **Carelon's provider website**
- **eServices user manual**
- **EDI transactions - 837 companion guide (behavioral health)**
- **EDI transactions - 835 companion guide**

Email contacts

Please email **Carelon Provider Services** or **Beacon Health's eSupport services**.

Telephone contact

Providers should have the practice or organization's TIN, the member ID number and date of birth, and the date of service available. Please call **Carelon Behavioral Health** for the claims hotline and IVR. An after-hours team is available until midnight to handle crisis calls.

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.

IVR

IVR provides telephone access via **Carelon Behavioral Health** for member eligibility, claim status and authorization status and is available for selected transactions.

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	EDI access	eServices access	Phone access	When applicable	Carelon receipt time frame	Other information
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

Transaction	EDI access	eServices access	Phone access	When applicable	Carelon receipt time frame	Other information
Resubmission of denied claim	N	N	N	A first-time claim is received by Carelon after the original 180 day filing limit and must include evidence that one of the following conditions is met: – 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.

Transaction	EDI access	eServices access	Phone access	When applicable	Carelon receipt time frame	Other information
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: – Under-payment (positive request) – Over-payment (negative request)	Within 180 days of the day of payment or non-payment 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.

Transaction	EDI access	eServices access	Phone access	When applicable	Carelon receipt time frame	Other information
Obtain claim status	N	Y	Y	Available 24 hours a day, 7 days a week 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 hours a day, 7 days a week 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 UB 04 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 **Carelon Health Options**.

Electronic claims

Claims may be submitted directly to Carelon via an 837 file or via the **Carelon provider portal** (registration required). The payer ID for Carelon is 43324. Carelon does not accept faxed claims.

Paper resubmission

- See the **claim transaction overview table** 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.

Of 180-day waiver

Please refer to the **waiver services table** within this provider manual for an explanation of waivers, when a waiver request is applicable and procedural guidelines.

1. Watch for notice of waiver requests becoming available on eServices.
2. Download the 180-day waiver form.
3. Complete a 180-day waiver form for each claim that includes the denied claims, per the instructions below.
4. Attach any supporting documentation.
5. Prepare the claim as an original submission with all required elements.
6. Send the form, all supporting documentation, claim and brief cover letter to **Carelon Health Options**.

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**.

- Please refer to the claim **transaction overview table** 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**.

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 the form is signed.

Chapter 9: Care management

Contact information pertaining to care management

Contact name	Contact information	Hours of operation
Humana Provider Services	Phone: 800-787-3311 (TTY: 711)	Monday through Friday, 7 a.m. to 7 p.m., Central time
Population Health	Website: Humana's Impact on Communities	

Our approach to care management

Humana provides comprehensive and integrated care management services through medical and behavioral health staff, social workers, and outreach specialists, which include one-on-one personal interaction and support for members. Additionally, Humana coordinates with community-based resources to assist members with SDOH, such as food, transportation to medical appointments, utilities, and so forth. For help with members who need assistance with SDOH, please contact **Population Health**.

Our care management program provides a broad spectrum of educational and follow-up services for your patients. We offer individualized education and support for many chronic diseases. Care management is especially effective for reducing admission and readmission risks, managing anticipatory transitions, engaging noncompliant members, reinforcing medical instructions and assessing social needs. We also offer a care management program designed for educating pregnant members and first-time mothers on the importance of prenatal care, childbirth, postpartum care and infant care.

MOC

Every SNP, including FIDE-SNPs, must have an MOC approved by the NCQA²⁶. The MOC provides the basic framework under which each SNP will meet patient needs. It serves as the foundation for promoting SNP quality, care management and care coordination processes.

Humana's MOC has 4 goals:

²⁶ § 1859(f)(7) of the SSA

- To improve member outcomes by coordinating care and ensuring care transitions
- To improve member access to and utilization of services and benefits
- To increase members' satisfaction with their healthcare experience and health status
- To ensure cost-effective service delivery

Humana achieves these goals by:

- Conducting HRAs to identify risk needs
- Developing a plan of care to address identified needs
- Providing access to an ICT

Humana's FIDE-SNP MOC includes, but is not limited to, the following functions:

- Provides the full scope of care coordination services for all members by stratifying them into an initial care management level of service
- Conducting MHS and health assessments, such as 6-week postpartum follow-up, maternity or post discharge emergency department or inpatient assessments, to identify the member's needs
- Reviewing all available historical information, including information from other Medicare payer sources, claims data and external records such as care plans and referrals
- Evaluating and ensuring members are placed within the most appropriate risk level and ensuring they receive care coordination to meet their needs
- Providing access to quality healthcare and support to all members based on an individualized assessment of care needs
- Monitoring for changes in condition or needs that warrant adjustment in the member's care coordination level of service
- Including processes and systems of care that engage members and family members in person-centered care management and culturally competent care
- Ensuring seamless transactions between levels of care and care settings, addressing all barriers to accessing appropriate services to support member health

Per CMS guidelines, all contracted providers serving SNP members must review and attest to our SNP annual training, which includes information on our MOC. To access the training and obtain additional information about the model, please refer to **Humana's Provider training compliance materials webpage**.

Care management services

Humana's care management program is a fully integrated health management program, supporting a holistic approach to healthcare by integrating physical and behavioral health while also considering environmental factors that impact health, such as food insecurity, housing and other SDOH. We implement an integrated, personal approach, supporting members from their initial assessment through the continuum of care with the goal of members taking an active part in their healthcare and

making healthy lifestyle decisions. We take a member-centric approach, placing them at the center of the process and working to identify members' health priorities to support them in meeting those goals. This approach also supports and enhances care and builds on the treatment you provide to your patient. We stress the importance of establishing a medical home, identifying early and ongoing barriers to care, and keeping appointments. When necessary, we assist in arranging transportation to the provider's office.

Humana encourages you to take an active role in your patient's care management program, and we invite and encourage you to direct and participate in the development of a comprehensive care plan as part of your patients' multidisciplinary care team. We believe communication and coordination are integral to ensure the best care for our members. Please contact care management for care management referrals and assistance with member needs.

Chronic and complex conditions

Humana's **clinical practice guidelines**, available to both affiliated and nonaffiliated providers, incorporate relevant, evidence-based medical and behavioral health guidelines (for preventive and certain nonpreventive acute and chronic conditions) from recognized sources such as professional medical associations, voluntary health organizations, and NIH centers and institutes. Identification of chronic conditions are assessed via CHAT or other state-approved assessments. Questions evaluate member knowledge and understanding of chronic conditions, the established relationship with the PCP and specialty providers, and completion of recommended monitoring visits and care.

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 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.
- 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.

Condition	Details
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 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
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 diuretics 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.
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 funduscopy exam every 12 months.
Glycohemoglobin	Humana acknowledges tight control of blood glucose levels can delay the onset and slow the progression of many of diabetes' side effects. Glycohemoglobin is a single 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.

Condition	Details
HEDIS COA measures (Humana Dual Fully Integrated program only)	Humana recognizes identification of issues related to medications, activities of daily living and pain management are important evaluations for Humana Dual Fully Integrated 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.
HIV/AIDS	Humana requires PCPs to assist members in obtaining necessary care in coordination with Humana Health Services staff. Please call Humana Provider Services for more details.
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.
Lipid levels	Humana recognizes the direct link between hyperlipidemia, secondary hyperlipoproteinemia 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.

Referral to complex case management

Humana offers individualized education and support to Humana Dual Fully Integrated members for many conditions and needs, including complex case management, assistance with housing and assistance accessing community support. Humana-contracted providers should reach out to Humana Provider Services to refer members in need of care management assistance.

Continuity-of-care requirements

Humana offers an initial 90-calendar-day transition period for new members to maintain a current course of treatment with an out-of-network provider. Humana offers a 90-calendar-day transition period for members transitioning to Humana from another plan. These transition periods apply 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.

Provider roles and responsibilities in continuity of care

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 PA 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 IP 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 PA if using out-of-network facilities
- Cooperating and communicating with other member service providers, including Supplemental Nutrition Programs for 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 PA 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 PA and referral processes and procedures
- Transmitting a member's transition record (discharge instructions) within 24 hours of discharge from an IP 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, the following apply:

Members maintain their current providers for 180 calendar days from the effective enrollment date or 90 calendar days if changing health plans. During the 180 calendar 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 manager roles and responsibilities

The role of care manager includes utilizing a person-centered care approach to develop a member's personal goals and preferences during the care planning process. Care managers perform assessment visits with members, which are centered around conducting a comprehensive assessment of the member's needs and current supports to develop a person-centered care plan. Members are encouraged to include anyone they would like present in the care planning process, during which the care manager discusses the member's needs, preferences and goals.

The role of care manager also includes assisting the member with defining personal goals and aspirations such as going back to school, going on a trip with friends, going to a dinner outing with family or obtaining desired living arrangements. In coordination with the care manager, the member and the member's authorized representative are required to develop, at minimum, 2 goals that are specific to the member's situation and needs as identified in their comprehensive assessment. Additionally, they work collaboratively to identify a personal goal that focuses on the member's

well-being and things that help the member feel motivated or happy. The care manager, member and their authorized representative may also develop a care goal that focuses on the member's medical or physical health. The care goal will reflect a current issue and barrier found during the comprehensive assessment. Care goals are required for members who wish to transition to a different living environment. The member's goals are documented in the plan of care. Goals are prioritized by numeric rank. Priorities reflect the member and caregiver's input, preferences, and reason why the goal is important to the member. The care manager will assess and document the member's current ability to contribute towards goals, how the member prefers to participate in the activity, potential challenges with the member's achievement of goals and resources available to assist the member with meeting the goal in the plan of care. The care manager will also document the member's progress toward meeting the established goals upon each contact with the member.

Humana care managers are available to work with members to coordinate referrals to community-based organizations and other services provided through interagency agreements.

Disease management programs

Humana members with emerging conditions and those with chronic conditions are eligible for enrollment in our disease management programs. Members who choose to participate in these programs receive educational information on how to better manage their condition and care options for them to discuss with you. Members identified as high risk are assigned a medical or behavioral health clinician who helps educate, coordinate and provide resources to the member to optimize their overall health.

Chronic and emerging conditions include:

- Asthma
- COPD
- Heart disease
- Diabetes
- Obesity
- Cancer
- Behavioral health and SUD issues
- Members with special healthcare needs
- Others as determined by Humana

If you have Humana-covered patients with any of these chronic conditions, and you believe they would benefit from this program, please contact **case management**.

Telephonic disease management

Low-risk members typically require support with care coordination and addressing SDOH. At a minimum these members have quarterly telephonic outreach plan-of-care updates. Prevention and wellness messaging and condition-specific materials are also provided.

Moderate-risk members typically demonstrate rising risk and need focused attention to support their clinical care needs and to address SDOH. Focus is on interventions targeted at the member's specific problems and aims to improve overall health and prevent further illness/disease progression or increase in risk. At a minimum these members have monthly telephonic outreach and plan of care updates.

High-risk members in intensive care management are those members who require the intensive, highly focused attention to support their clinical needs.

Member reassessments

The care manager evaluates the ICP on a quarterly basis (at a minimum) to confirm the services contained within are meeting the member's needs and that the member is making progress toward health and personal goals. Information found to the contrary prompts a full or partial reassessment and update to the ICP. In addition, a trigger event or change in the member's condition may signal the services on the ICP are not sufficient to meet the member's needs, including needs related to chronic condition management, preventive care, social needs or remaining in the least restrictive setting. The care manager completes a timely full or partial reassessment and ICP after a trigger event or change in condition.

MOC and care coordination

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

Provider participation

The provider's participation is key and includes:

- Participation in ICT care conferences via phone and exchange of written and in-person communications
- Participation in communications to foster care coordination
- Promotion of HEDIS and 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).

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 calendar 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.

Stratification methodology

We employ the following process to determine the initial and ongoing stratified care coordination level of service for all members:

- Identify members systematically and stratify them into an initial care coordination level of service using integrated data streams from multiple sources using predictive modeling tools and enrollment report data.
- Conduct the state HNS tool and review all available historical information including information from aligned and unaligned D-SNP payers as well as other payer sources. Additionally, the care coordinator reevaluates the stratified care coordination level of service for appropriateness and determines if there is a need for a rush designation.
- Conduct the CHAT or brief CHAT and review all available historical information, including information from aligned and unaligned Medicare payers as well as other payer sources. Additionally, the care coordinator reevaluates the stratified care coordination level of service for appropriateness and determines if there is a need for a rush designation.
- Monitor continually for changes in condition or needs that warrant adjustment in the member's care coordination level of service, based on associates' interaction with members and data-derived insights.
- Reevaluate annually the member's care coordination level of service and reassign as appropriate based on the member's needs.

Member engagement

Our outreach process to engage our members includes 4 telephonic attempts and a letter. If our initial efforts to reach the member are unsuccessful, the care coordinator dispatches a community health worker for in-person outreach.

LTSS outreach efforts include unannounced home visits to the member's last known address. We also coordinate with providers and formal supports to obtain updated contact information. If engagement remains unsuccessful, a certified letter is sent to the member.

Should the member and/or caregiver opt out of care coordination, we have established protocols and continue to monitor for change in status and/or risk. For members we are unable to reach, we also utilize multiple methods to identify the correct number via medical records, claims, pharmacy and/or providers.

Assessments

We use evidence-based comprehensive assessments, such as the state HNS tool and CHAT, to assist in identifying gaps and further modify the stratification based on clinical judgment. We also utilize additional assessments that allow us to hone in on specific topics and special needs (e.g., disease-specific, SDOH, environmental, wellness plan, disaster plan) to create a comprehensive ICP.

Members are assessed using the most appropriate assessments based on their level of care, current setting and service delivery options (e.g., home, assisted living, adult day health and self-directed).

Our assessments process supports the evaluation of certain conditions and systems, such as:

- Advance care planning
- Anxiety/depression
- Assessment of activities of daily living
- Bowel/bladder
- Cognitive impairments
- Evaluation of gait and fall prevention
- Health maintenance: preventive care and chronic disease management
- Informal caregiver burden
- Medications including polypharmacy evaluation and inappropriate use of medications
- Mobility
- Nutrition
- Oral health
- Pain
- Sensory impairment
- Skin
- Sleeping patterns
- Transitions

The care coordinator also uses all available clinical information, input from the PCP and other ICT members, and historic claims to gain a full picture of the member's needs.

As part of the initial, quarterly and annual on-site assessment and care planning visit with members in nursing facilities, the service coordinator conducts the previously mentioned needs assessments and all other state-approved assessments deemed necessary by the service coordinator. The service coordinator and care coordinator jointly assess the member's potential for an interest in transition to the community at least annually, engaging the long-term care ombudsman as applicable.

The service or care coordinator conducts an informal caregiver assessment using a state-developed or state-determined tool as part of the initial on-site visit with new members receiving LTSS or as part of the on-site intake visit for current members applying for LTSS. In addition, the care coordinator administers this assessment to all other members with an informal caregiver (with member consent)

as part of the initial assessment visit. The informal caregiver assessment includes, at a minimum:

- An overall assessment of the informal caregivers providing services to the member to determine the willingness and ability of the informal caregivers to contribute effectively to the needs of the member, including employment status, schedule and other caregiving responsibilities
- An assessment of the informal caregiver's own health and well-being, including medical, behavioral, physical, social or environmental limitations, such as food, utility, housing and healthcare insecurities, as they relate to the informal caregiver's ability to support the member
- An assessment of the informal caregiver's level of stress related to caregiving responsibilities and potential feelings of being overwhelmed
- Identification of the informal caregiver's needs for training in knowledge and skills assisting the person needing care
- Identification of all service and support needs for training in knowledge and skills to be better prepared for the caregiving role
- Identification of the member's SDOH needs, including current or potential lack of healthcare, food insecurity, utility instability, housing insecurity, transportation issues, and more

The care coordinator and service coordinator complete a reassessment at least annually; after a state-defined trigger event; or after member or ICT request. This includes a review of the member's progress toward achieving health and personal goals. The care coordinator and service coordinator review the reassessment results with the member and the member's ICT, further described, to inform updates to the member's ICP.

All assessments are available in the member portal and viewable by providers with member/caregiver consent.

Reassessments

We will reassess members:

- When their circumstances or needs change significantly
- At the request of the member
- No less often than annually
- When an identified state trigger event occurs

With the member's consent, the member's family and informal caregivers can participate in reviewing and updating the member's ICP.

The care coordinator and service coordinator, if applicable, will conduct a CHAT on site and provide the results to the state for an updated NFLOC determination.

For all LTSS (including HCBS and SNF) residents, the state conducts an annual level-of-care reassessment and sends it to the care coordinator and service coordinator to update the care plan and complete any additional assessments needed.

When a state trigger event is identified, the care coordinator reassesses the member's needs no later than 5 business days after the event occurs. These events include:

- A significant healthcare event including, but not limited to, a hospital admission, a transition between healthcare settings or a hospital discharge
- A change or loss of informal caregiver
- A decline in social status (increased isolation/loneliness)
- A change in the home setting or environment if the change impacts 1 or more areas of health or functional status
- A change in diagnosis that is not temporary or episodic and that impacts 1 or more areas of health status or functioning
- A request by the member or member's designee, caregiver, provider, the member's ICT or the state

Members who are on a complex medical regimen and/or behavior modifying medication will be reassessed by an ICT clinician every 6 months to ensure the effectiveness and desired outcomes are accomplished.

Plan

The care coordinator and service coordinator (if engaged) review recommended interventions with the member based on the identified needs and the member's personal and health goals. Humana creates a person-centered ICP and a service plan for each of our Illinois managed LTSS members. The member's ICP is available to view in the provider portal. The care coordinator shares updates or changes to the ICP with the member's chosen ICT via the provider portal, member portal or other ICT-preferred methods to request feedback and input. This feedback is shared with the member prior to ICP finalization. Our care coordinator will contact you to request member information or ask for your participation in ICT conversations. Your role, as a provider, is to cooperate and engage with our care management team.

Implement

The ICP

The ICP is based on:

- Initial and ongoing HRAs and comprehensive assessment results
- Claims history
- ICT-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 ICP indicates the steps to be taken by the care coordinator and service coordinator to ensure the member has access to needed services and support. Following ICP creation, the care coordinator and service coordinator use the ICP to guide their next steps, including communicating with providers, executing the appropriate community-based referrals and providing member

education and resources. During each subsequent contact, the care coordinator and service coordinator discuss the member's progress toward the ICP's goals, whether the member is accessing all listed services and supports and whether adjustments are needed to meet the member's needs or help the member achieve goals. ICP modifications are shared with the member's ICT for awareness and feedback.

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

The ICT

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
 - Creation of a written healthcare directive, also known as a living will

Providers should ensure members are informed of their right to advance directives.

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

Behavioral health diagnoses

When working with 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.

Provider communication and reporting expectations

- 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.

Domestic violence

PCPs should screen members for signs of domestic violence and offer referral services to applicable domestic violence prevention community agencies.

Alcohol and substance use

Members should be screen members 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

Smoking cessation

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 discussing the quitting process

Review and modification of the ICP as the member's healthcare needs change

The ICP is formally reviewed and modified at least annually. In addition, during each monthly and/ or quarterly contact between the care coordinator, service coordinator and member, the care coordinator and/or service coordinator review the member's goals and ICP to determine if the services rendered meet the member's needs. If not, the care coordinator and service coordinator work with the member and ICT to make the necessary modifications.

The care coordinator and service coordinator also conduct a reassessment and update the ICP to reflect the member's changing needs following a trigger event.

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

Behavioral health care management referrals

Humana members have access to care managers who provide a holistic approach to addressing the member's physical and behavioral healthcare needs as well as SDOH. We also offer chronic condition management programs for behavioral health and SUDs. Humana-contracted providers may contact us to refer members needing care management assistance by calling **Case Management**. Humana adheres to a "no wrong door approach" to care management referrals.

We encourage you to refer members who might need individual attention to help them manage special healthcare challenges to our care management programs. For direct access, please contact **Case Management** or **Population Health**. Please note that LTSS members are automatically enrolled into case management/care coordination, so no referral is needed for them.

Behavioral health service providers are required to refer members with known or suspected and/or untreated physical health problems or disorders to their PCP for examination and treatment, with the member's or the member's legal guardian's consent. Behavioral health providers may only provide physical healthcare services if they are licensed to do so.

Humana assists with your referrals, scheduling appointments and coordinating an integrated approach to the member's health and well-being by coordinating care between behavioral health providers, PCPs and specialists. Behavioral health providers are required to send initial and quarterly summary reports to the member's PCP and to refer members for PCP follow-up on untreated physical health concerns when identified.

Electronic visit verification and service gap reporting procedures for LTSS

Providers of personal care services and home health services are required to utilize EVV to electronically monitor, track and confirm personal care and home health services provided in the home setting²⁷.

Personal care services include:

- Respite care (skilled or unskilled)
- Attendant care
- Homemaker services

Home health services include:

- Home infusion
- Home health visits (home health aide, licensed practical nurse and registered nurse)
- PT
- OT
- ST
- PT, OT and/or ST evaluations

Federal law requires that providers use the EVV system to document the following information:

- Date of service
- Location of service
- Individual providing service
- Individual receiving the service
- Type of service
- Time the service begins and ends

Service gaps are identified and must be addressed in a timely manner, including gaps in critical services. Providers play an important role in supporting the timely notification to Humana of missed visits and/or schedule changes.

²⁷ 21st Century Cures Act

If providers discover the information in the EVV portal does not match the current authorization on file, the provider is advised to contact **Humana Provider Services** for support. The International Journal of Critical Infrastructure Protection is using Sandata as the state-sponsored system for implementing federal EVV requirements. During the initial authorization process, providers are provided contact information to encourage active collaboration and participation in the ICT process. The provider agency can execute a member's backup plan by finding an alternative employee for the scheduled service at the scheduled time, alerting the service coordinator of the need to either support the scheduled service or implement other measures.

Please refer to the **claims and billing chapter of this provider manual** for more information.

Chapter 10: Quality management and improvement

Contact information pertaining to quality management and improvement

Contact name	Contact information	Hours of operation
Humana Provider Services	Phone: 800-787-3311 (TTY: 711)	Monday through Friday, 7 a.m. to 7 p.m., Central time

Quality improvement program overview

Humana's quality improvement program is a comprehensive program that encompasses clinical care, preventive care, population health management and Humana's administrative functions. It is designed to objectively and systematically monitor and evaluate the quality, appropriateness, accessibility and availability of safe and equitable medical and behavioral health services. Strategies are identified and activities implemented in response to findings. Using a continuous quality improvement methodology, the QMIP works to:

- Monitor systemwide issues
- Identify opportunities for improvement
- Determine the root cause of problems identified
- Explore alternatives and develop a plan of action
 - Activate the plan, measure the results, evaluate effectiveness of actions and modify the approach as needed

The QI activities include monitoring clinical indicators or outcomes, quality studies, HEDIS measures, CAHPS® program results, National Core Indicators Survey—Aging and Disabilities results and medical record audits. The QMIC is delegated by Humana's internal board of directors to monitor and evaluate the results of program initiatives and to implement corrective action when the results are less than desired or when areas needing improvement are identified.

The QIC is accountable to Humana's executive management team. The goals of the QI include:

- Developing clinical strategies and providing clinical programs that look at the whole person, while integrating behavioral and physical healthcare.
- Identifying and resolving issues related to member access and availability to healthcare services

- Providing a mechanism where members, practitioners and providers can express concerns to Humana regarding care and service
- Providing effective customer service for member and provider needs and requests
- Monitoring coordination and integration of member care across provider sites
- Monitoring, evaluating and improving the quality and appropriateness of care and service delivery to members through peer review, QIPs, medical/case record audits, performance measures, surveys and related activities
- Providing a comprehensive strategy for population health management that addresses member needs across the continuum of care
- Providing mechanisms to assess the quality and appropriateness of care furnished to members with special healthcare needs
- Providing mechanisms to detect both underutilization and overutilization
- Providing mechanisms where members with complex needs and multiple chronic conditions can achieve optimal health outcomes
- Guiding members to achieve optimal health by providing tools that help them understand their healthcare options and take control of their health needs
- Monitoring and promoting the safety of clinical care and service
- Adopting reimbursement models that incentivize the delivery of high-quality care
- Promoting better communication between departments and improved service and satisfaction to members, practitioners, providers and associates
- Promoting improved clinician experience for providers and all clinicians to promote member safety, provider satisfaction and provider retention

Activities of the QI team include developing clinical practice guidelines, reviewing medical record documentation, monitoring HEDIS measures, measuring member satisfaction and performing external quality reviews.

Quality Management and Improvement Committee

The Humana QIC provides a formal venue to review and direct the quality activities of the plan. The QIC meets quarterly and reports to the corporate quality improvement committee. Humana's market regional vice president leads the committee. The QIC membership comprises leadership across the organization, including but not limited to utilization management, physical and behavioral health including LTSS support, pharmacy, market operations, quality compliance, provider relations, health equity, and provider contracting. The QIC contains voting members showcasing multidepartment representation of the centralized and regionalized areas of operations. Their recommendations are expected to be based on sound operational data, in support of member service and well-being. The QIC is responsible for the following:

- Reviewing and approving any changes to the QIPD, work plan and/or annual evaluation

- Monitoring and reviewing work plan execution, performance on quality and outcome measures and progress toward goals and performance of QIP initiatives
- Reviewing and approving any changes to quality management policies and procedures
- Tracking and managing responsibilities of quality management staff and assessing compliance with program expectations
- Managing the dissemination of information to providers regarding quality outcomes

The QI team is responsible for the following:

- The CAC comprised of members and various stakeholders as requested by member feedback; Meetings are held quarterly
- The SAC comprised of various advocacy groups including aging and disability, homemaker services, and community partners; Meetings are held quarterly

Quality measures

Humana monitors, measures and evaluates provider quality using identified standards, appropriateness of care and service delivery (or the failure to provide care or deliver services) to members, including members enrolled in specialty plans, through the following means:

Measure	Description
Medical record audits	Medical record audits are reviews of medical records to evaluate patterns of complaints regarding poor quality of service, poor quality outcomes and adherence to member record documentation standards.
Peer reviews	Peer reviews are reviews of the provider's practice methods, patterns and appropriateness of care.
Performance improvement projects	Performance improvement projects include ongoing measurements and interventions, significant improvement to the quality of care and service delivery, sustained over time, in both clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction.
Performance measures	Performance measures include data collected on member outcomes as defined by HEDIS or otherwise defined by the state.
Surveys	Survey measures include the CAHPS.

HEDIS and other performance measures

HEDIS is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. HEDIS includes care coordination measures for members transitioning from a hospital or emergency department to home for which hospitals and providers have additional responsibilities. Humana may conduct medical record reviews to validate HEDIS measures. In addition to medical record reviews, information for HEDIS is gathered administratively via claims, encounters and submitted supplemental data. There are 2 primary routes for supplemental data:

- Nonstandard supplemental data involves directly submitted, scanned images (e.g., PDF documents) of completed attestation forms and medical records. Nonstandard data also can be accepted electronically via a proprietary Electronic Attestation Form or Practitioner Assessment Form. Submitted nonstandard supplemental data is subject to audit by a team of nurse reviewers before ending a HEDIS improvement opportunity.
- Standard supplemental data flows directly from a single electronic database (e.g., population health system, EMR) to another without manual interpretation. Therefore, standard supplemental data is exempt from audit consideration. Standard supplemental data can be accepted via HEDIS-specific custom reports extracted directly from your EMR or population health tool and is submitted to Humana via either secure email or FTP transmission. Humana also accepts lab data files in the same way. Humana partners with various EMRs to provide member summaries and detail reports and to automatically retrieve scanned charts.

Quality Improvement (QI) program

Humana has a QI program that includes the following:

- PIPs
- Over- and under-utilization measures
- Annual analysis of plan demographics, including clinical, geographical and cultural data points, to identify high-risk populations, areas of network need, member education opportunities and performance improvement opportunities
- Assessment of access and availability of network providers, including after-hours availability of PCPs
- Assessment of quality and appropriateness of care furnished to children with special healthcare needs
- Continuity and coordination of care
- HEDIS measurement
- CAHPS review
- Annual measurement of effectiveness review of the QI

We welcome healthcare providers' input regarding our QI program.

CAHPS

The CAHPS survey includes measures that reflect member satisfaction with your care and service. Each year surveys are sent to our members that ask multiple questions of how you and Humana are performing. Humana monitors and evaluates your quality, appropriateness of care and service delivery to members using this measure along with other measures of your satisfaction, behavioral health surveys and special surveys implemented to support quality/performance improvement initiatives.

Encounter validation study

Accurate and complete encounter data is critical to the success of any managed care program.

State Medicaid agencies rely on the quality of the encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. The completeness and accuracy of this data is essential to the success of the state's overall management and oversight of its Medicaid managed care program and in demonstrating its responsibility.

Provider participation in the Quality Management and Improvement Program

Network providers are contractually required to comply with Humana's QMIP, which includes providing member records for assessing quality of care and external quality review organization activities.

In addition, the HIPAA Privacy Rule²⁸ and rules and regulations promulgated thereunder²⁹ permit a covered entity (provider) to use and disclose PHI to health plans without member authorization for treatment, payment and healthcare operations activities. Healthcare operations include but are not limited to the health plan conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs, care management and care coordination. Providers also must allow Humana to use your performance data.

Evaluation of the Quality Management and Improvement Program

Humana evaluates the effectiveness of the QMIP on an annual basis. The annual report reviews completed and continuing QMIP activities, assesses the progress in meeting goals, addresses the quality of clinical care and service, trends measures to assess performance in quality of clinical care and quality of service, identifies any corrective actions implemented or corrective actions that are recommended or in progress, and identifies any modifications to the QMIP. Information regarding the QMIP is available upon request.

Medical record requirements

Providers must maintain a detailed and comprehensive health record that reflects all aspects of care for each member. Providers must maintain medical records in a secure, timely, legible, current, detailed, accurate and organized manner that permits effective and confidential member care and quality review and facilitates accurate follow-up treatment.

²⁸ 45 C.F.R. § 164.506

²⁹ 45 C.F.R. Parts 160, 162, and 164

Confidentiality of member information must always be maintained. Records should be safeguarded against loss, destruction or unauthorized use and must be accessible for review and audit. Such records must be readily available to Humana, the state and/or its designee within the time frame identified in the request and contain all information necessary for the UM of each Humana member. Providers must have procedures in place to permit the timely access and submission of health records to Humana on request. Failure to submit records in a timely manner may result in additional action and follow-up.

Providers must maintain individual health records for each Humana member. On reasonable request by a member, providers must provide a copy of a member's medical record at no charge. Procedures also should exist to facilitate the prompt transfer of member care records to other in-plan or out-of-plan providers.

Minimum standards for member medical records

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, the member's representative, the member's 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 monitors this process through an approved policy and procedure that is available upon request.

A member's medical record must include the following information, at minimum:

- The identity of the individual to whom service was rendered
- The identity of the provider rendering the service
- The identity, including date signature or initials, and position of the provider employee rendering the service, if applicable
- The date on which the service was rendered
- The diagnosis of the medical condition of the individual to whom service was rendered (relevant only to providers, optometrists and dentists)
- A detailed statement describing the type and duration of services rendered
- The location where services were rendered
- The amount claimed through Medicaid for each specific service rendered
- Written evidence of provider involvement, including signature or initials, and personal member evaluation to document the acute medical needs, excluding HCBS services
- Plan of treatment and progress notes that confirm effectiveness of treatment, including regular evaluations to assess performance and refine goals when applicable (e.g., pest control and home modification would not require a treatment plan)
- X-rays, mammograms, electrocardiograms, ultrasounds and other electronic imaging records

Medical records should be signed (manually or electronically), dated, preserved and maintained by

the provider for a minimum of 7 years unless federal requirements mandate a longer retention period (e.g., immunization and tuberculosis records are required to be kept for a person's lifetime).

Providers must permit Humana and representatives of the state to review members' medical records for the purposes of monitoring provider compliance with medical record standards, capturing information for clinical studies and monitoring quality or any other reason. Identified areas for improvement are tracked and corrective actions are taken as indicated. Effectiveness of corrective actions is monitored until problem resolution occurs. Information from the health records review may be used in the recredentialing process.

Medical record confidentiality requirements

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

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

You must ensure compliance with privacy and security provisions.³⁰ Humana and providers must agree to maintain the confidentiality of information contained in your records regarding healthcare services rendered to members as required by state or federal law, rule, or regulation, including without limitation to HIPAA privacy and security requirements.³¹

Medical record storage requirements

Confidentiality of member information must always be maintained. Records are to be stored securely with access granted to authorized personnel only. Access to records should be granted to Humana, or its representatives, without a fee to the extent permitted by state and federal law. Providers must have procedures in place to permit the timely access and submission of health records to Humana upon request. Information from the health records review may be used in the recredentialing process as well as quality activities.

Member rights related to medical records

Humana members have the right to confidentiality and to be sure that others cannot hear or see them when receiving medical care. They have the right to get help with their medical records in accordance with applicable state and federal laws, and to be sure that their medical records are kept private. They have the right to ask for and receive a copy of their medical records and to be able to ask that their health records be changed or corrected if needed. Records should be retained for 5 years or longer as required by federal law. Members also have the right to say yes or no to having their information given out unless Humana must provide it by law.

³⁰ HIPAA and 42 C.F.R. Part 431, Subpart F

³¹ 42 C.F.R. Part 431, Subpart F; 42 C.F.R. § 438.224; 45 C.F.R. Parts 160 and 164

Medical record reviews

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

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

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

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

You must maintain complete and accurate fiscal, medical, social and other administrative records for medical services rendered to Medicaid managed care plan members and as are necessary to document the quality, appropriateness and timeliness of services performed under this contract and in compliance with applicable state and federal laws, rules and regulations and the state contract.

Such records must specifically include pertinent books, financial records, medical/case records and records of financial transactions.

You must agree to maintain and retain these records for a period of 10 years following the termination of Humana's contract with the state.

In addition to record retention requirements for your licensure, subcontractors are required to retain, as applicable, the following information:³²

- Member grievance and appeal records³³
- Base data³⁴
- MLR reports³⁵
- Data, information and documentation³⁶

The information listed above must be retained for a period not less than 10 years from the close of the contract and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by Humana if the subcontract is continuous.³⁷

32 42 C.F.R. § 438.3(u)

33 42 C.F.R. § 438.416

34 42 C.F.R. § 438.5(c)

35 42 C.F.R. § 438.8(k)

36 42 C.F.R. § 438.604, 42 C.F.R. § 438.606, 42 C.F.R. § 438.608 and 42 C.F.R. § 438.610

37 42 C.F.R. § 438.3(h)

Humana requires that each member or member's representative is entitled to 1 free copy of the member's medical record. Additional copies are made available to members at cost.

Complete medical records include:

- Medical charts
- Prescription files
- Hospital records
- Provider specialist reports
- Consultant and other healthcare providers' findings
- Appointment records
- Other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of services

Humana periodically requests member medical records as part of our provider monitoring as described in the **member medical record review section of this provider manual**. Humana realizes that supplying medical records for review requires your staff's valuable time; your cooperation with our requests and associated timelines is appreciated.

Humana offers the following suggestions to ensure complete and accurate documentation of member services:

- Use legible handwriting for paper medical records.
- Consider dictated notes, which can improve comprehension of medical records while reducing the chance of misinterpretation.
- Include the patient's name on front and back of every page of the medical record.
- Initial and date lab results in the medical record to indicate review by a provider.
- Record all patient visit dates and sign all chart entries.
- Consider using preprinted forms to document all aspects of comprehensive services, such as EPSDT exams.

Compliance plan

Compliance and ethics

At Humana, we serve a variety of audiences: members, providers, government regulators and community partners. We serve them best by working together with honesty, respect and integrity. We are all responsible for complying with all applicable state and federal regulations along with applicable Humana policies and procedures. Humana is committed to conducting business in a legal and ethical environment. A compliance plan has been established by Humana that:

- Formalizes Humana's commitment to honest communication within the company and within the community, inclusive of our providers, members and employees

- Develops and maintains a culture that promotes integrity and ethical behavior
- Facilitates compliance with all applicable local, state and federal laws and regulations
- Implements a system for early detection and noncompliance reporting with laws and regulations; fraud, waste and abuse concerns; or noncompliance with Humana policy, professional, ethical or legal standards
- Allows us to resolve problems promptly and minimize negative impact on our members or business including financial losses, civil damages, penalties and sanctions
- Acts according to professional ethics and business standards
- Ensures member privacy standards through strict adherence to best practices in combating HIPAA violations
- Creates a cultivated curriculum of education training and materials for members, staff, contractors and member caregivers to share critical content
- Establishes effective monitoring and audits to help ensure accurate claims and the identification of risks, particularly in high-volume service areas
- Notifies us of suspected violations, misconduct, or fraud, waste and abuse concerns
- Cooperates fully with any investigation of alleged, suspected or detected violations of applicable state or federal laws and regulations

We appreciate your commitment to compliance with ethics standards and the reporting of identified or alleged violations of such matters.

Member safety

Humana supports implementation of a complete range of member safety activities. These activities include medical record legibility and documentation standards, communication and coordination of care across the healthcare network, utilization of evidence-based clinical guidelines to reduce practice variations, and tracking and trending adverse events/quality of care issues and grievances related to safety and quality of care.

Member safety also is addressed through adherence to clinical guidelines that target preventable conditions. Preventive services include:

- Regular checkups for adults
- Tests for cholesterol, blood sugar, colon and rectal cancer, bone density, and sexually transmitted diseases, and Pap tests and mammograms

Preventive guidelines address prevention and/or early detection interventions and the recommended frequency and conditions under which interventions are required. Prevention activities are based on reasonable scientific evidence, best practices and member needs.

Prevention activities include distribution of information, encouragement to use screening tools, and ongoing monitoring and measuring of outcomes. While Humana implements activities to identify interventions, the support and activities of families, friends, caregivers, providers and the community have a significant impact on prevention.

Preventive guidelines and clinical practice guidelines

The Preventive and Clinical Practice Guidelines are evidence-based medical and behavioral health guidelines from recognized sources such as professional medical associations, voluntary health organizations, and NIH centers and institutes. Humana considers the needs of our members when adopting guidelines. Humana reviews newly adopted and updated clinical practice guidelines in its QMIC under the direction of the medical director and participation of contracted network providers. The guidelines can help providers make decisions regarding appropriate healthcare for specific clinical circumstances. Condition-specific and/or disease-related practice guidelines include elements such as:

- Overview of condition/disease
 - Information related to anticipating, recognizing and responding to condition/disease-related symptoms
 - Information related to best practice standards for prevention and management of condition/disease
 - Guidelines/process for the ICT to use regarding negotiating incorporation of condition/disease prevention and management plan with member into the care plan
- Plan for quality assurance monitoring of guideline effectiveness

We encourage providers to consider and refer to these guidelines as applicable. You remain responsible for determining the applicable treatment for each individual. Humana monitors your adherence to guidelines using claim, pharmacy and utilization data. Areas for improvement are identified. Education is provided via Humana's Provider Newsletter highlighting guidelines that are identified as being in an outlier status. The newsletter includes links to the identified guidelines.

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

- Provider manual updates
- Provider communications
- Provider website

Providers also can receive preventive health and clinical practice guidelines through **Humana Provider Services**. Clinical practice guidelines also are available to providers, members and the public on **Humana's clinical practice guidelines website**.

Please refer to the **chronic and complex conditions section of this provider manual** for more details about clinical practice guidelines.

Provider and member satisfaction surveys

Humana conducts an annual provider satisfaction survey that includes questions to evaluate your satisfaction with our services, such as claims, communications, UM and provider services. We encourage you to participate and respond to the survey as the results are analyzed and used to develop provider-related QI initiatives.

Compliance with availability and access standards are monitored regularly through random sampling, review of member concerns and member satisfaction surveys to ensure members have reasonable access to providers and services.

Peer review

Peer reviews are reviews of your practice methods, patterns and appropriateness of care. Providers are responsible for complying with the peer review process.

Chapter 11: Utilization management

Contact information pertaining to utilization management

Contact name	Contact information	Hours of operation
Carelon National Provider Services Line	Phone: 800-397-1630 (TTY: 800-345-9049) Fax: 855-371-9232 Website: Carelon Behavioral Health website	Monday through Friday, 7 a.m. to 7 p.m., Central time 24 hours a day, 7 days a week
Clinical Intake team (CIT)	Phone: 800-523-0023	Monday through Friday, 7 a.m. to 7 p.m., Central time
Humana Clinical Pharmacy Review	Phone: 800-555-2546 Fax: 877-486-2621	Monday through Friday, 7 a.m. to 10 p.m., Central time
Humana Provider Services	Phone: 800-787-3311 (TTY: 711)	Monday through Friday, 8 a.m. to 8 p.m., Central time
IVR line	Phone: 800-787-3311	Monday through Friday, 8 a.m. to 8 p.m., Central time
Medicare and Medicaid health service line	Phone: 800-322-2758, option 2, ext. 1500130	Monday through Friday, 7:30 a.m. to 4 p.m., Central time
Medication intake team	Phone: 866-461-7273 Fax: 888-447-3430	Monday through Friday, 7 a.m. to 10 p.m., Central time
Overutilization Review and Monitoring department	Phone: 833-410-2496 Fax: 502-996-8184 Email: CPORM@humana.com	Monday through Friday, 7 a.m. to 4:30 p.m., Central time

Utilization management program overview

Our UM program is designed to ensure members receive access to the right care, in the right place, at the right time. Our goal is to optimize the member's benefits by providing quality healthcare services that meet professionally recognized standards of care; are a covered benefit, medically necessary and appropriate for the individual member's condition; and are provided at the most appropriate level of care.

Humana does not reward providers or our staff for denying coverage or services. There are no financial incentives for Humana staff to encourage decisions that result in underutilization. Humana does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition. Services supporting individuals with continuing or chronic conditions or who require LTSS are authorized in a manner that reflects the member's ongoing need for such services and supports. Authorization does not guarantee payment. Authorization is based on medical necessity and is contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and or qualifications and are determined when the claim is received for processing.

The UM department performs all UM activities including PA, concurrent review, discharge planning and other activities that monitor IP and outpatient admissions and procedures to ensure appropriate medical care is rendered in the most appropriate setting, using the most appropriate resources. Only healthcare professionals with appropriate clinical expertise in treating the member's medical condition, performing the procedure or providing the treatment, or a licensed doctorate-level behavioral health clinician provider in Illinois or may deny a service authorization request based on medical necessity criteria or authorize a service in an amount, duration or scope that is less than requested.

We ensure behavioral health services are integrated and coordinated with physical health services, regardless of whether the member resides in a facility or the community, and that behavioral health services are provided as part of the treatment continuum of care. Humana completes an assessment of satisfaction with the UM process on an annual basis, identifying areas for improvement.

UM helps maintain the quality and appropriateness of healthcare services provided to Humana members. Utilization review determinations are based only on appropriateness of care and service and existence of coverage. Humana does not reward providers or staff for denying coverage or services.

Humana also monitors the coordination of medical care to ensure its continuity. Referrals to the Humana care management team are made, if needed.

Humana completes an annual assessment of satisfaction with the UM process, identifying areas for improvement.

Access to UM staff

Providers may contact the UM staff with any UM questions. Please keep the following in mind when contacting UM staff:

- Medical and behavioral health inquiries can be directed to the **Humana PA Team**.
- Staff can receive inbound communications regarding UM issues after normal business hours.
- Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff are accessible to answer questions about the UM process.

In the best interest of Humana members and to promote positive healthcare outcomes, Humana

supports and encourages continuity of care and coordination of care between medical providers as well as between behavioral health providers.

Member health is always Humana's top priority. Provider reviewers from Humana are available to discuss individual cases with attending providers on request. Clinical criteria and clinical rationale or criteria used in making UM determinations are available at **Medical and Pharmacy Coverage Policies**, in the Humana Physician News newsletter and upon request by emailing **Humana Provider Services**.

Upon request and at no cost to you, Humana supplies all documents, records and other information relevant to an adverse payment or coverage determination. If you want to request a peer-to-peer discussion on an adverse determination with a Humana provider reviewer, please send an email Humana Provider Services above within 5 business days of the determination.

PA

PA is defined as a process through which the healthcare provider is required to obtain advance approval from Humana to determine 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 PA since it does not result in approval or denial.

You are able to access PA lists online via the **Humana provider PA and notification lists website** to determine which medications and/or services require PA. Please refer to the current PA and notification lists section of the **Humana provider PA and notification lists website**.

Note: There are 2 separate PA and notification lists; one is for Humana Dual Fully Integrated plan members only and one is for LTSS only.

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

- Member's state Medicaid ID number, date of birth and address
- Dates of service or hospital admission
- Requesting provider name, address, NPI and TIN
- Rendering provider name, address, NPI and TIN
- OPR provider information
- Preparer's name, phone and fax number
- ICD diagnosis codes
- Procedure/service codes and description
- Modifiers
- Taxonomy
- Place of service
- Relevant clinical information

Submitting all relevant clinical information at the time of the request is strongly encouraged and

will facilitate a quicker determination. If additional clinical information is required, a Humana representative will request the specific information needed to complete the authorization process. CMS mandate requires the NPI is included for authorization requests. As a result, your NPI will be required on authorization requests submitted to Humana as of Dec. 9, 2023. This requirement applies to authorization submissions and inquiries (Inquiry 278 per the state) for all providers (requesting/referring provider, rendering/treating provider and rendering/treating facility) and lines of business, except atypical providers. Submissions that do not have an NPI will be returned for resubmission. A list of Humana contracted vendors who handle certain authorization types is available online at the **Humana provider PA and notification lists website**. As submission of such authorization requests may vary from our regular processes, Humana asks that you check this page prior to submitting a request for authorization. For pharmacy, please refer to the **Pharmacy chapter of this provider manual**.

Services that require PA

Humana offers providers an **authorization lookup tool** using CPT and HCPCS codes. Providers may contact **Humana Provider Services** to request a hard copy of the PAL.

Note: The PAL is subject to change.

Changes to the PA requirements will be posted a minimum of 45 calendar days prior to the effective date of the change on the **Humana provider PA and notification lists website**.

Medical services and behavioral health/SUD services are evaluated for addition or removal from the PAL, utilizing the same factors in accordance with the MHPAEA. Requests for PA should be made as soon as possible but at least 14 calendar days before the service date. If PA is required and not obtained, reduction or denial of payment may result.

Services provided without PA also may be subject to retrospective review. When retrospective review is required, providers must include clinical information to perform a medical necessity review, as well as a summary of why PA was not obtained.

Requesting PA

Humana PA

Medical service PA can be submitted online via **Availity Essentials**, fax, or by contacting Humana's **IVR** line.

Medication PA can be submitted via phone by calling or faxing the **medication intake team**. Request forms are available on our **PA for professionally administered drugs website**.

For many services, you can respond to a series of questions when requesting PA. 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.

You may also submit a B2B or batch Health Care Services Review and Response transaction (278) via EDI or call the number on the back of the patient's member ID card.

If a request must be expedited due to the seriousness of a patient's condition, please contact Humana Provider Services.

Carelon PA

Behavioral health PA is handled through **Carelon Behavioral Health PA**. You can submit PA requests for behavioral health on **Carelon's website** (registration required) or via IVR, phone or fax.

Requests should be made as soon as possible but at least 14 days before the service date.

Note: Emergency and urgent care does not require PA. However, providers should notify Humana within 48 hours of initiation of these services.

If PA is required and not obtained, the result may be reduction or denial of payment. Services provided without PA may also 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 PA was not obtained.

Referrals

Humana members may see any participating provider within our network, including specialists and IP hospitals. 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. Please refer to **Humana's claim payment information 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 **PA section of this provider manual** as well as on **Humana's provider PA notification lists website**. The PCP will receive 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 and/or facility
- Medically necessary

An approved referral number does not override member eligibility, provider agreement exclusions, etc. Prior to the specialist rendering services, PA also must be obtained by the specialist for any additional medications or services on the **PA and notification list**.

Referral status

The status of a referral can be verified by visiting **Availity Essentials** or by contacting **Humana Provider Services**. 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 must also submit claim/encounter data to Humana.

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 Humana Dual Fully Integrated members, Humana follows Original Medicare billing and enrollment requirements for services and supplies covered under Original Medicare, which includes Parts A and B only.

Medication PA

PA for medications and services on the PA and notification list is required. The list is available on [Humana's provider PA notification lists website](#) or by calling **Humana Provider Services** directly and requesting a printed copy.

Inpatient coordination of care (concurrent review)

Concurrent review is the process that determines coverage during the IP stay, including stays in an acute IP facility, SNF, LTAC 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 detailed in the special requirements for hospitals section of this provider manual.

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 Humana Dual Fully Integrated plans, Humana applies Medicare NCDs and LCDs as well as Illinois Medicaid coverage guidelines. Humana medical coverage policies are developed in accordance with current evidence in widely used treatment guidelines or clinical literature.

A licensed, board-certified medical director reviews all available clinical documentation to confirm guidelines are met. This medical director renders a decision in accordance with clinical review guidelines and currently accepted medical standards of care, accounting for the individual circumstances of each case. If you receive an adverse determination, you will receive a denial letter

that includes the criteria used to make the decision. You can also obtain the guidelines used to make a specific adverse determination by contacting the **Medicare and Medicaid Health Service Line**, or access policies through **Humana's medical and pharmacy coverage policies website** or the **Humana Physician News newsletter**.

Special requirements for hospitals

Hospital discharge rights for Humana Dual Fully Integrated members

CMS requires hospitals deliver the Important Message from Medicare (IM), CMS-10065, to all Medicare beneficiaries, including Humana Dual Fully Integrated plan members who are hospital IPs.

Hospitals are required to provide the IM to the Humana Dual Fully Integrated plan 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 **available on the CMS website**.

The IM informs hospitalized Humana Dual Fully Integrated members about their hospital discharge appeal rights. Humana Dual Fully Integrated members who are hospital IPs have the statutory right to request an immediate review by a QIO when Humana, the hospital and provider determine IP 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 the patient's representative personally, the hospital staff should call the representative to advise them of the member's rights as a hospital patient. At a 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 the 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 a separate entry in the member's file.

Ensure the documentation includes the name of the staff person initiating 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.

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 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 the member's authorized representative on behalf of Humana, but no later than noon of the day after the QIO notified 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, please refer to the [CMS FFS & MA IM website](#).

Medicare Outpatient Observation Notice (MOON) requirement

The Federal NOTICE ACT³⁸ requires hospitals and CAH to provide the MOON to Original Medicare beneficiaries and Humana Dual Fully Integrated plan members or their authorized representatives. This includes beneficiaries who do not have Part B coverage, beneficiaries who are subsequently admitted as an IP 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 IPs, and the reasons for their status.

Additional important information

- Hospitals and CAHs are responsible for providing the written MOON and a verbal explanation of the notice to all Original Medicare and Humana Dual Fully Integrated 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

³⁸ Public Law 114-42 passed August 6, 2015, amended § 1866(a)(1) of the SSA

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 must still 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 online.**

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/Humana Dual Fully Integrated 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 Notices and Forms website.**

Providers can also 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 the member's 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 must also 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 and 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 of the NOMNC on the day that it is made, indicating all 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 Humana Dual Fully Integrated 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 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 can still appeal through Humana's Appeals department.

For more information about notification of termination requirements, providers can refer to the **CMS Termination Notices website**.

Self-referrals

Members may self-refer to any participating provider. PCPs do not need to arrange or approve these services for members if applicable benefit limits have not been exhausted. Exceptions to this policy apply to members who have been designated to participate in the **Right Choices Program**.

The PCP is responsible for recommending or initiating referrals for specialty care as needed. However, Humana does not require a referral from the member's PCP for some self-referred services. Referrals may be made by the PCP for specialty care and other medically necessary services, both in- and out-

of-network, when such services are not available within the Humana network. The PCP is responsible for maintaining clinical records regarding referrals in a complete and accurate medical record that meets or exceeds the state specifications.

Service plan authorization

Humana partners with members to support the development of its member-directed service plans to deliver services that are person-centered, participant-driven, and holistic, and address members' SDOH, involving their caregivers, as appropriate. The member, the member's designated representative (if applicable), providers and all others involved in and/or responsible for the service plan and its implementation must sign the service plan either electronically or in writing for it to be completed.

The member's service plan is the authorization for services to be delivered. Humana does not require providers to submit additional authorization requests for these services. The service plan is the authorization for the services. The member's service plan is integrated into the member's overall ICP.

If the member disagrees with the service plan, the member may sign indicating disapproval. If this occurs, the plan provides the member with a denial notice within 2 business days. The denial notice will include information on the member's right to file a grievance. A copy of the signed service plan is provided to the member and all the ICT members.

Special considerations

LTSS service authorizations

Humana does not interfere with the member's setting of choice once level of care is determined.

If a member is determined eligible for NFLOC, Humana does not deny an authorization for the member to receive necessary care in an in-network nursing facility. Likewise, Humana will not deny authorization for that same member to receive the necessary care at home instead of in a facility.

HCBS

Humana will authorize HCBS based on the member's current needs assessment, consistent with the member's person-centered service plan.

Specialized behavioral health services

Residential SUD services that include short-term, low-intensity and high-intensity residential treatment for opioid use disorder (OUD) and other SUDs in settings of all sizes, including facilities that qualify as institutions for mental disease (IMD), are a covered benefit under the Humana Dual Fully Integrated program.

PA is required for all residential SUD stays.

When residential services are determined medically necessary for a member, Humana approves the number of days based on medical necessity. If a facility determines that a member requires additional time after the initial approval of days, the provider should submit a concurrent review authorization request. That request shall include things such as a reassessment of risk, progress or barriers to achieving treatment plan goals, and updated treatment plan objectives. Additional days will be

reviewed for medical necessity. Notifications of determination of requests of initial and concurrent review are rendered within state-mandated turnaround times. Please refer to the **time frames and notifications for responding to PA requests section of this provider manual** for more information.

Institutions for mental disease (IMDs)

SMI

Humana covers short-term stays in an IMD for SMI under state regulations. IMD treatment is a medically appropriate and cost-effective substitute for behavioral services covered under the state plan in other settings. Humana may use IMD services in lieu of other behavioral health services when medically appropriate. Humana allows Humana Dual Fully Integrated members between the ages of 60 and 64 an average length of stay not to exceed 30 calendar days for all IMD stays for SMI. If medically necessary, a maximum of 60 calendar days may be approved for short-term IMD stays for SMI.

SUD

Humana covers short-term stays in an IMD for SUD under state regulations. Humana allows Humana Dual Fully Integrated members between the ages of 60 and 64 up to 15 calendar days for a short-term IP stay in a calendar month as medically necessary for individuals with a diagnosis of SUD. If the member's IMD SUD stay exceeds 15 calendar days in a calendar month and the member is awaiting placement in a state-operated facility (SOF)

for treatment, the member is disenrolled from the plan and enrolled in a fee-for-service plan. For SUD stays in an IMD exceeding 15 calendar days in a calendar month in which the member is not awaiting placement in an SOF, the member will remain enrolled in the Humana Dual Fully Integrated program, and the state will recover the entire monthly capitation payment for the member.

Humana covers short-term crisis residential stays for SUD in a qualified IMD for Humana Dual Fully Integrated members age 60 to 64 per medical necessity requirements and not to exceed an average length of stay of 30 calendar days.

Humana is paid monthly capitation payments by the state to cover short-term inpatient stays for SMI in a qualified IMD for members age 60 to 64 per medical necessity requirements and not to exceed an average length of stay of 30 calendar days. A maximum stay of 60 calendar days can be approved, if medically necessary, for short-term IMD stays for SMI members.

Humana will coordinate with IMDs and providers to coordinate care for members. This will include anticipating and planning for a member's discharge and coordination of follow-up services.

For Humana Dual Fully Integrated members up to age 64, IMD stays are subject to medical necessity reviews only.

Hospital admissions

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

- Member's name
- Member's ID number, name and date of birth

- Date of actual or proposed admission
- Date of proposed procedure
- Bed type: IP or outpatient
- NPI of treatment facility or hospital
- Applicable ICD diagnosis code
- Caller's telephone number
- Attending physician's telephone number

For urgent PA or notifications, you should call **Humana Provider Services**. Press "0" or say "representative" for live help, and have your NPI available.

PA in transitions of care

Humana will avoid disruption or sudden changes in the member's home health services without good cause and will consider the case history of each member and prioritize consistency in services. If denial or reduction of hours occurs, Humana will work with the requesting provider and member to create a safe transition plan instead of stopping services abruptly. When a transition plan is needed, the UM clinician will initiate a referral to the assigned care coordinator. In addition, the clinician may initiate an ICT meeting if needed.

Coordination of care will occur for new Humana members transitioning into the plan. In the event a new member is receiving a previously authorized ongoing course of treatment with any provider, Humana will cover the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or nonparticipating providers.

Humana will cover MMA services until the member's PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the member's treatment plan no more than 90 calendar days after the effective date of enrollment.

Providers should continue servicing Humana members during the 90-calendar-day continuity of care period for any services that were previously authorized or prescheduled prior to the implementation, regardless of whether the provider participates in Humana's network. Providers should keep previously scheduled appointments with new members during the transition.

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

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

If the services were arranged prior to enrollment with the plan, written documentation includes the following:

- Behavioral health services
- Prescriptions (including prescriptions at nonparticipating pharmacies)
- Prior existing orders

- Provider appointments (e.g., dental appointments, surgeries, etc.)

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

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

- Assign the member a new care manager
- Continue care plan as-is for up to 90 calendar days
- Contract with nonparticipating providers if at all possible
- Coordinate and build relationships with providers
- Determine unmet needs and put necessary services in place
- Emphasize the member's comfort and safety while addressing unmet needs
- Ensure there are no disruptions in care
- Identify members who desire to transition to another setting (provide continuity of care)
- Reassess and update the personalized plan of care

Time frames and notifications for responding to PA requests

Standard PA

Humana will provide notice of decision as expeditiously as the member's health condition requires but no later than 7 calendar days following receipt of the request for service. If Humana fails to respond to a PA request not pertaining to medications within 4 days of receiving the necessary documentation, authorization is considered granted.

Expedited PA

When you indicate, or Humana determines, that following the standard time frame could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function, Humana completes an expedited authorization as expeditiously as the member's health condition requires and provides the decision and notice no later than 48 hours after receipt.

Concurrent reviews

Concurrent requests are requests in which the member is in the process of receiving the requested medical care or services, even if Humana did not previously approve the earlier care. Notice of decision is provided as expeditiously as the member's health condition requires but no later than 48 hours after receipt.

Retrospective determinations

Humana will provide a notice of decision within 30 calendar days of receipt of the retrospective request. Humana will not retroactively deny authorization for the continuation of care unless the provider submitted the authorization in an untimely manner.

For authorization originally approved by Humana, if we deny the continuation of services with the SNF or long-term attendant care, we must provide at least 5 days of coverage for the services from the date of the notice of denial to ensure the safe discharge of the member. This requirement does not apply for authorization submitted in an untimely manner by the provider.

For requests related to HCBS, Humana will make an expedited authorization decision and issue notice to the member within 24 hours of the decision to deny authorization for services contained in the member's service plan. Under no conditions will Humana extend the 24-hour time frame.

When there are any decisions to terminate, suspend or reduce previously authorized covered services because of probable member fraud verified by the Illinois Office of Inspector General or the attorney general, Humana will provide notice 5 business days before the date the indicated service would be terminated, suspended or reduced.

Humana notifies the requesting provider and provides written notice of all determinations that deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested.

Court-ordered services

Humana provides medically necessary and covered behavioral health services pursuant to court orders. These services are furnished in the same manner as services furnished to other members.

Notification requirements for hospital admissions and hospice care

Observation requirements

Humana pays the contracted or fee schedule rate for observation stays, regardless of whether a related emergency visit was determined emergent. Providers can maintain members for more than 23 hours in observation when the member has not met criteria for admission, but the treating physician believes that allowing the member to leave the facility would likely put the member at serious risk. The observation period cannot last more than 3 calendar days or 72 hours. Humana does not require PA for observation stays. However, notification is requested so we can assist with discharge planning and follow up with the member for any needs.

Inpatient requirements

Humana requires the provider to submit notification of all IP admissions within 1 business day of the date of admission. With appropriate consent, Humana will notify the member's provider when a member is hospitalized or receives emergency treatment within 5 calendar days of the hospital IP admission or emergency treatment.

Hospice requirements

Humana requires notification within 10 calendar days of the date of hospice election or the start date of a hospice benefit period for members who reside in a nursing facility and have elected to use the hospice benefit. Notifications can be submitted through **Availity Essentials**.

Notification can be made using the **Notification to HFS of Illinois Medicaid Hospice Benefit form**. This form can be submitted online via **Availity Essentials**, or by calling **Humana Provider Services**.

Discharge planning

Humana believes that discharge planning is a key part of treatment and should begin at admission. Our UM staff reviews appropriateness of discharge planning as part of the clinical review to ensure the appropriateness of the member's transition plan from inpatient/higher levels of care.

Humana is available to assist in the coordination of care when a member is being discharged from a facility or transferring from one level of care to another to ensure the member's successful transition. The IP UM nurse works with the member, the member's authorized representative, the member's PCP, the facility care team and other providers, as appropriate. In the event Humana is notified of a facility closure or license termination, we collaborate with the Office of the Long-Term Care (LTC) Ombudsman and local ombudsman to ensure all member transfer and discharge rights are upheld. Humana's care or service coordination staff meets in person with facility staff and each member residing in the facility to initiate person-centered discharge planning within 90 days of receiving the notice of closure. Humana's care or service coordination staff collaborates with the facility and the Office of the LTC Ombudsman and local ombudsman to ensure the facility allows at least 90 days for the member's transfer out of the facility. Fewer than 90 days is permissible only if the member or authorized representative agrees with the transfer and all aspects of continuity of care are in place. Information and the communication of transfer options are based on the member's person-centered care plan and current medical and psychosocial condition. The information is communicated in person and in writing to the member. Humana requires that members receiving IP psychiatric services are scheduled for outpatient follow-up or continuing treatment prior to their discharge. This treatment must be provided within 7 days of the date of the member's discharge.

Medical necessity review

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 IP basis, medical necessity means appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an IP 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 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.

All decisions are based on eligibility, coverage and medical necessity criteria. Humana uses the following hierarchy for medical necessity reviews:

- A. Federal law
- B. State plan
- C. Noncustomized MCG™, ASAM for SUD treatments, Medicare NCDs and LCDs
 - a. For MCG, diagnosis/procedure-specific guidelines will be used before general guidelines.
 - b. For Medicare guidelines, NCDs are used before LCDs for Illinois.
- D. Humana clinical coverage policies
 - a. Professional society guidelines—guided by published, peer-reviewed literature
 - b. Professional references/ SME—guided by published, peer-reviewed literature
- E. Best standards of care—guided by published, peer-reviewed literature

As Humana applies coverage policies and medical necessity criteria, we consider individual member needs and an assessment of the local delivery system.

These guidelines are intended to allow Humana to provide all members with care that is consistent with national quality standards and evidence-based guidelines. These guidelines are not intended as a replacement for a provider's medical expertise; they are to provide guidance to our providers related to medically appropriate care and treatment. If a member's clinical information does not meet the criteria for approval, the case is forwarded to a medical director for further review and determination.

Clinical criteria used in making a UM determination is available upon request by contacting **Utilization Management**.

PA requests review process

If additional clinical or other information is needed to determine medical necessity, Humana will request the relevant information. When requesting necessary information, at least 2 attempts are completed, including via telephonic outreach and/or fax. The request will clearly indicate what additional information is required to complete the PA request. Humana may request additional clinical information to complete the medical necessity review, when needed, but will not request documentation that would change the authorized services or hours.

Retrospective review

A retrospective review is a request for a review for authorization of care, a service or a benefit for which an authorization is required but not obtained before the delivery of the care, service or benefit. Humana requires PA to ensure covered patients receive medically necessary and appropriate services. Claims not meeting the necessary criteria as described below will be administratively denied.

On request, Humana only allows for a retrospective authorization submission after the date of service when PA is required but not obtained.

When submitting a retroactive authorization request, please include the following documentation:

- Patient name and Humana ID number
- Authorization number of the previously authorized service for the related request
- Clinical information supporting the service

A retrospective review request for inpatient and outpatient services can be submitted via

Availity Essentials

For requests submitted via Availity Essentials or by fax, you can check the status online on Availity Essentials. You can see the authorization status along with the authorization number associated with the request. Some outpatient authorization requests may auto-approve if the procedure code is not listed on the **Humana's provider PA notification lists website**. Written notification for approved service requests is not provided unless requested. Requests for written notification can be included when clinical information is submitted or by calling **Humana Provider Services**.

Exceptions to this policy apply to member is in the **Right Choices Program section of this provider manual**.

Services that do not require PA

Humana covers emergency and post-stabilization services without PA for both in- and out-of-network facilities.

Peer-to-peer (P2P) discussions

For Humana Dual Fully Integrated plans, this 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 preclaim dispute. As part of this preclaim dispute, providers can request a P2P conversation if one did not occur before the adverse determination. Participating providers can also submit claim dispute as detailed in the **member grievances and appeals section of this provider manual**.

P2P consultations are conducted among healthcare professionals who have clinical expertise in treating the member's condition, with the equivalent or higher credentials as the requesting/ordering provider. The P2P consultation must clearly identify what documentation the provider needs to

provide to obtain approval of the specific item, procedure or service or a more appropriate course of action based on accepted clinical guidelines.

Appeals

Appeals may be requested if Humana denies a PA request. The appeal request is separate from the P2P request. A provider, acting on behalf of the Humana Dual Fully Integrated member, and with the member's written consent, may file an appeal. Appeals must be filed within 60 calendar days of the date of the adverse benefit determination notice.

Appeals can be filed by:

- Calling **Humana Provider Services**
- Completing the **Medical Service Appeals Request Form**
- Writing a letter including the following information:
 - Member name
 - Member ID number from the front of the member's Humana Dual Fully Integrated ID card
 - Member address and phone number
 - All information that will help explain the appeal

Mail the form or letter to Humana's **Grievances and Appeals department**.

Humana acknowledges receipt of the appeal within 3 business days of the day we received the appeal. If we extend the time frame for the appeal, we make reasonable efforts to provide a prompt oral notice of the delay. We send written notice of the reason for the decision to extend the time frame. We also inform the member of the right to file a grievance if there is disagreement with that decision.

The member or the member's representative can:

- Review all information used to make the decision
- Provide more information throughout the appeal review process
- Examine the member's case file before and during the appeal process

This includes medical records, clinical records, other documents and records, and all new or additional evidence considered, relied on or generated in connection with the appeal. This information is provided, on request, free of charge and sufficiently in advance of the resolution time frame.

If the member or the member's appointed representative feels waiting for the 30-day time frame to resolve an appeal could seriously harm the member's health, a request can be made for an expedited appeal.

You can request an expedited appeal if a delay could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain or regain maximum function.

If an expedited process is not required, we make reasonable efforts to provide prompt oral notice, and the appeal will go through the normal process. We also inform the member of the right to file a grievance if there is disagreement with that decision.

Humana decides on expedited appeals within 48 hours after the plan receives notice of the appeal, unless this time frame is extended. Humana also must make a reasonable attempt to give the member prompt oral notice by phone. Written notice of appeal disposition must be provided to the member, and where appropriate, the provider. Notice is given within 5 business days of resolution.

Negative actions are not taken against:

- A member who files an appeal
- A provider that supports a member's appeal or files an appeal or expedited appeal on behalf of a member with written consent

External review by an independent review organization (IRO)

A Humana Dual Fully Integrated member, the member's authorized representative, or a provider acting on the Humana Dual Fully Integrated member's behalf, with written consent, may file a written request for review of Humana's decision by an IRO. A member who exhausts Humana's appeal process may request an external review within 120 calendar days of the date on Humana's notice of resolution. An external review does not restrict or replace the member's right to appeal Humana's decision to a State Fair Hearing. A member may seek external review by an IRO, and this process can run concurrently with a State Fair Hearing.

Requesting external review by an IRO

Request for external review, along with all supporting documentation, must be submitted to the **Grievances and Appeals department**.

When requesting an independent review, members or their representatives may submit new or other relevant documentation as part of the request. The IRO will render a decision to uphold or reverse Humana's decision within 72 hours for an expedited appeal or 15 business days for a standard appeal. The determination made by the IRO is binding to Humana.

For more information about external review by an IRO, please contact **Humana Provider Services**.

State Fair Hearing

The member, the member's authorized representative or the member's provider, with written consent, may request a State Fair Hearing within 120 calendar days of exhausting Humana's grievance and appeal process. The State Fair Hearing process may run concurrent to an external review by an IRO.

If dissatisfied with the outcome of the State Fair Hearing, the member may request an agency review within 10 calendar days of the administrative law judge's decision.

To request a State Fair Hearing, the member or the member's representative should send the request to the **Office of Administrative Law Proceedings—State Fair Hearings**.

Reconsideration process after medical necessity denials

The reconsideration process is defined as the process Humana follows to review additional clinical documentation from providers to determine if a denial or partial denial should be overturned and

approved, based on medical necessity criteria. If the service requested is denied or partially denied, you may request reconsideration of the denial determination. Providers who request reconsideration must submit additional information to Humana (via phone, fax, web, etc.) within 18 months of the date of the denial or partial denial determination to facilitate the reconsideration process.

Humana reviews all new clinical information received for reconsideration requests and renders a decision based on the new documentation. If the reconsideration is received with no new clinical information or beyond the 60 day submission requirement, the original decision will stand. The member or member's authorized representative may choose to file an appeal through the grievance and appeals process, more information about which is available in the **member grievances and appeals chapter of this provider manual**.

Second medical opinions

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

Humana complies with all Illinois Humana Dual Fully Integrated member requests for a second opinion from a qualified professional. Humana does not require a second opinion for surgery or other medical services. However, providers or members may request a second opinion at no cost. If a qualified provider is not available to give a second opinion in a timely manner, Humana arranges for the member to obtain the second opinion outside of the network at no cost to the member.

The following criteria should be used when selecting a provider for a second opinion. The provider:

- Must participate in the Humana network; if not, PA must be obtained
- Must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained
- Must be in an appropriate specialty area

Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

Out-of-network services

An out-of-network provider is not directly contracted with the Humana plan. Humana is not responsible for payment of services provided by an out-of-network provider without written PA. Humana authorizes out-of-network care, based on medical necessity, when a network provider is not available to provide members with medically necessary covered services in a timely manner.

Humana coordinates payment with the out-of-network provider to confirm that costs to the member are not greater than they would be if the service were provided in network. Humana also takes

into consideration continuity of care and long-term specialized care needs, including oncology and transplant services.

Noncontracted services

Noncontracted services are services not defined on Schedule B of your contract. Humana is not responsible for payment of noncontracted services. If you or your staff identifies a service that a member may require that is not listed in your contract, please contact the member's Humana care manager to evaluate the member's needs and determine if the service can be authorized by Humana. If the care manager determines the service should be authorized by Humana, the care manager will contact **Humana Provider Services** to discuss adding an addendum to your contract.

Utilization management delegation

Humana does not delegate physical health or behavioral health PA functions to subcontractors, with the exception of dental, vision and pharmacy.

Right Choices Program

The Right Choices Program (RCP) is designed for individuals enrolled in the Humana Dual Fully Integrated program selected for review based on their behavior patterns and utilization practices compared with other members of the same population. Reviews may also be initiated by referral based on reports of potential overuse or abuse from various sources such as providers or other agencies. It is intended to limit overuse of benefits while providing an appropriate level of care for the member. Humana will educate RCP members on how to properly use their health insurance.

Humana monitors claim activity for signs of misuse or abuse in accordance with the state and federal laws. If a review of a member's claim activity reveals overutilization of covered services such as excessive ER visits, doctor shopping/visits, large number of controlled substance prescriptions filled at different pharmacies and/or misuse of prescriptions, the member is considered a candidate for RCP.

After the review process, if it is determined that the member is overusing or abusing services, the member is placed in the RCP, which includes increased care coordination, provider assignment, member education and interventions. The member is locked in to a single primary care provider (PCP) and a single pharmacy. If the member requires services from a different provider, such as a specialist, the PCP must submit a referral.

Members identified to be enrolled in the RCP receive written notification from Humana, along with the option to select a designated lock-in pharmacy and PCP. If a PCP and pharmacy are not selected within an appropriate time frame, a selection will be made for the member.

The member will receive written communication that provides the following information:

- Name, address and phone number of the designated provider and pharmacy
- How to handle an emergency
- How to request an override

- Member responsibilities
- Effective and end date of program enrollment
- Length of limitation
- Rights to appeal the decision

The PCP must use referrals if the RCP member requires evaluation or treatment by a specialist or another provider or needs to use the pharmacy other than the primary lock-in pharmacy. The purpose of the referral is to ensure the PCP has authorized the visit to the referral provider.

If you or the member have questions, please feel free to contact Humana by contacting the **Overutilization Review and Monitoring department**. After hours, please leave a voicemail with the member's name, Medicaid ID number, contact phone number and a detailed description of your request.

Chapter 12: Claims and billing

Contact information pertaining to claims and billing

Contact name	Contact information	Hours of operation
Medical claims	Mail: Humana Claims Office P.O. Box 14359 Lexington, KY 40512-4359	
LTSS claims	Mail: LTSS Humana Claims Office P.O. Box 14359 Lexington, KY 40512-4359	
Behavioral health claims	Mail: Behavioral health Carelton Behavioral Health P.O. Box 1866 Hicksville, NY 11802-1866	
Encounters	Mail: Humana Claims Office P.O. Box 14055 Lexington, KY 40512-4055	
Humana Provider Services	Phone: 800-787-3311 (TTY: 711)	Monday through Friday, 7 a.m. to 7 p.m., Central time
Woburn Claim Appeals	Phone: 844-231-7949	Monday through Friday, 8 a.m. to 5 p.m., Central time

Introduction

Humana maintains and complies with HIPAA standards for the submission and adjudication of claims. This section will provide information regarding submission and payment process. If you have questions or would like training regarding submitting claims, please contact **Humana Provider Services**.

Electronic claim submission

Humana accepts electronic claims through these clearinghouses:

- **Availity Essentials**
- **Optum**
- **TriZetto®**
- **SSI Group**

When filing an electronic claim, use one of the following payer IDs:

- **61101** for noncapitated fee-for-service claims
- **61102** for capitated encounter claims
- **61105** for delegated encounter claims
- **BHOVO** for Caredon Behavioral Health claims

Behavioral health claims should be submitted electronically via:

- **Caredon Behavioral Health eServices**

Note: Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for more information.

Paper claim and encounter submission

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

- **LTSS claims**
- **Medical claims**
- **Behavioral health claims**
- **Encounters**

Claim forms

CMS-1500

For a CMS-1500 form or its electronic equivalent:

- Enter "yes" in box 10-B.
- Enter the accident date in field 14.
- Enter all diagnosis codes in section 21.
- Attach the following to the claim, if available:
 - Copy of the check from the primary insurance carrier
 - Copy of the EOB from the primary insurance carrier

- Copy of the exhaustion denial letter from the primary insurance carrier
- Personal injury protection (PIP) worksheet, if available
- Statement from the member indicating no PIP coverage, if applicable

UB-04

For a UB-04 form or its electronic equivalent:

- Enter occurrence code 01 or 02, as applicable, and the accident date in fields 33-35.
- Enter value code 14 in fields 39-41.
- Enter all diagnosis codes in fields 67-76.
- Attach the following to the claim, if available:
 - Copy of the check from the primary insurance carrier
 - Copy of the EOB from the primary insurance carrier
 - Copy of the exhaustion denial letter from the primary insurance carrier
 - Statement from the member indicating no PIP coverage, if applicable

Timely filing requirements

Timely filing requirements are outlined below. If a claim is submitted after the applicable timely filing term, the claim will be denied for untimely filing.

• Initial claims:

- Claims that do not involve a third-party payer for services rendered must be submitted within 90 calendar days of the date of service or from discharge for in-network providers and 6 months from the date of service or from discharge for out-of-network providers.
- Humana's timely filing limits for your claims are within 90 calendar days of the date of the claim's recovery or recoupment notice from the previous payer. This timely filing requirement will be waived in cases of member retroactive coverage. If a claim is denied for COB information needed, you must submit the appropriate remittance statement from the primary payer within the remainder of the initial claim timely filing period.

• Corrected claims:

- Corrected claims that were originally denied are considered initial claims, and they also must be submitted within 90 calendar days of the date of service or from discharge for in-network providers or 6 months from the date of service or from discharge for out-of-network providers.
- Corrected claims that were originally paid or partially paid must be submitted within 60 calendar days of the date of service or from discharge for both in-network and out-of-network providers.

• Claim resubmissions:

- 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 payer's RA or EOB.

- 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. Please include the label “ATTN: Claims Dept. —Reconsideration Claim” when submitting reconsideration requests [SH6] [MM7] to the 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
- **COB:**
 - If a member has other insurance and Humana is secondary, you may submit for secondary payment within 60 calendar days of the other insurance payment date.
 - COB electronic claims require a copy of the members' primary carrier's payment information, including the COB indicator of either MA or MB for Medicare coverage and for Medicare Advantage coverage.
 - COB claims (including Medicare and commercial) submitted beyond the 60-day limit must have a copy of the appropriate remittance statement that is not more than 60 calendar days from the primary payer's EOB date attached to each claim form involved to verify that the original claim was received within 60 calendar days of the service date. COB paper claims require a copy of the EOP from the primary carrier. If a copy of the claim and EOB are not submitted within the required time frame, the claim is denied for untimely filing.
 - If a claim is denied for COB information needed, you must submit the primary payer's EOB for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 60 calendar days from the primary payer's EOB date. If a copy of the claim and EOB are not submitted within the required time frame, the claim will be denied for untimely filing.

Minimum claim requirements

Humana is 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.

Humana follows CMS billing requirements, except in those instances where Illinois HFS policies differ, in which case HFS guidelines will supersede the CMS requirements. This provider manual incorporates and indicates those differences where applicable. It is important Humana has accurate and up-to-date provider information on file to ensure timely claims processing.

IMPACT

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 TIN 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.

Categories of service and specialties

Although categories of service (COS) are not directly added to a claim submitted to Humana via the specialties and subspecialties registered in the HFS provider IMPACT system, they are critical to accurate claims payment. If the appropriate specialty or subspecialties 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.

Required information on claims

All claims must include the following information:

- Member name
- Member address
- Insured's ID number: Be sure to provide the complete Medicaid ID for the member.
- Member's date of birth: Always include the member's date of birth so we can identify the correct member.
- Place of service: Use standard CMS location codes.
- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis codes
- HIPAA-compliant CPT or HCPCS codes and modifiers when modifiers are applicable
- Units, where applicable (anesthesia claims require number of minutes)
- Date of service: Please include dates for each individual service rendered; date ranges are not accepted, even though some claim forms contain from/to formats. Please enter each date individually.

- PA number, when applicable: A number is needed to match the claim to the corresponding PA information. This is only needed if the service provided required PA.
- NPI: Please refer to the **Location of Provider NPI, TIN and Member ID number section of this provider manual**.
- Federal TIN or provider Social Security number: Every provider practice (i.e., legal business entity) has a different TIN.
- Billing and rendering taxonomy codes that match the Master Provider List (MPL)
- Billing and rendering addresses that match the MPL
- Your signature or supplier: Your complete name should be included. If we already have the provider's signature on file, indicate "signature on file," and enter the date the claim is signed in the date field.

Institutional claims for IP, outpatient, ASC and LTC services must be billed with an attending NPI. We do not pay claims with incomplete, incorrect or unclear information.

Illinois Medicaid provider number

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

NPI, TIN and taxonomy

Providers must have an NPI in accordance with the Social Security Act.³⁹

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, including:⁴⁰

Individuals or organizations that furnish atypical or nontraditional services that are only indirectly related to the provision of healthcare (e.g., 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 (e.g., billing services and repricers)

Your NPI and TIN are required on all claims, in addition to your provider taxonomy and specialty type codes (e.g., FQHC, RHC and/ or primary care center), using the required claim type format (CMS-1500, UB-04 or Dental ADA) for the services rendered. Atypical providers are not required to have NPIs.

Atypical providers are not considered healthcare providers and include waiver providers, transportation providers (other than ambulances and air ambulances) and medical review team copy centers. Atypical providers are required to use their state provider IDs instead of NPIs.

³⁹ § 1173(b) of the Social Security Act, as enacted by § 4707(a) of the Balanced Budget Act of 1997

⁴⁰ 45 C.F.R. § 160.103

Applying for NPIs and TINs

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. Apply online by signing in to the **National Plan and Provider Enumeration System (NPES)** (registration required).
- 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**, where staff will enter the application data into NPES. 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**.

Providers can share NPIs with Humana online through **Availity Essentials**. 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 or 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.

Professional claims	Facility/institutional 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).	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).
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 EOB or an RA that clearly states how the claim was paid or the reason for denial.	Used when billing for facilities services, including nursing home room and board, supporting living room and board, hospice, and intermediate care facilities.

Location of provider NPI, TIN and member ID number

Humana accepts electronic claims in the 837 ANSI ASC X12N (005010A1) file format for both professional and hospital claims.

On 5010 (837P) professional claims:

The provider NPI should be in the following location:

- 2010AA loop—billing provider name
- Identification code qualifier—NM108 = XX
- Identification code—NM109 = billing provider NPI
- 2310B loop—rendering provider name
- Identification code qualifier—NM108 = XX
- Identification code—NM109 = rendering provider NPI
- For form CMS-1500, rendering provider taxonomy code in box 24J.ZZ, qualifier in box 24I for rendering provider taxonomy

The billing provider TIN must be submitted as the secondary provider identifier using an REF segment, which is either the employer identification number for organizations (EIN) or the Social Security number for individuals:

- Reference identification qualifier—REF01 = EI (for EIN) or SY (for Social Security number)
- Reference identification—REF02 = billing provider TIN or Social Security number
- The billing provider taxonomy code in box 33b on 5010 (837I) institutional claims

The billing provider NPI should be in the following location:

- 2010AA loop—billing provider name
- Identification code qualifier—NM108 = XX
- Identification code—NM109 = billing provider NPI 76

The billing provider TIN must be submitted as the secondary provider identifier using an REF segment, which is either the EIN for organizations or the Social Security number for individuals:

- Reference identification qualifier—REF01 = EI (for EIN) or SY (for Social Security number)
- Reference identification—REF02 = billing provider TIN or Social Security number
- The billing taxonomy code in box 81 on all electronic claims

The attending provider NPI is required when submitting claims for IP, outpatient, ambulatory ASC and LTC services. The attending provider should always be an individual person, not the NPI of the group to which the rendering provider may be linked. A taxonomy for the attending provider is optional. The attending provider NPI should be in the following location:

- 2310A loop – attending provider name
- Identification code qualifier – NM108 = XX
- Identification code – NM109 = attending provider NPI

- The Humana member ID number should go on:
- 2010BA loop = subscriber name
- NM109 = member ID number

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 online within the **Health Care Provider Taxonomy**.

The taxonomy code used must match a corresponding COS, procedure code (PC) and/or POS. A **crosswalk of taxonomies with COS, PC and POS is available on the HFS website**.

5010 transactions

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic healthcare and pharmacy transactions. This action was taken in preparation to implement ICD-10-CM codes in 2015. The new standard is the HIPAA 5010 format.

The following transactions are covered under the 5010 requirements:

- 837 Claims encounters
- 276/277 Claim status inquiry
- 835 Electronic remittance advice
- 270/271 Eligibility
- 278 PA requests
- 834 Enrollment

Provider billing for services

Network providers must provide services and supplies and receive payment in accordance with their contractual agreement with Humana.

Service encounter submission

Providers are required to submit timely, complete and accurate encounter claims in accordance with contract requirements and applicable regulations. Accurate and complete encounter data is critical to Humana's success. State Medicaid agencies rely on the quality of the encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. The completeness and accuracy of this data is essential to the success of the state's overall management and oversight of its Medicaid managed care program and in demonstrating its responsibility and stewardship. The state has the right to audit all encounter data at its choosing. This often includes validating the information on the encounter against providers' medical records. In

the event of an encounter data validation review, providers may be asked for their medical records in support of the encounters submitted.

Provider portal

Humana partners with **Availity Essentials** to allow providers to reference member and claim data for multiple payers by signing in only once. **Availity Essentials** provides information on the following:

- Eligibility and benefits
- Claim submission
- Claim status
- Remittance advice

To learn more, call **Availity Essentials** or visit **Availity Essentials** online.

EFT/ERA enrollment through Humana

Get paid faster and reduce administrative paperwork with EFT and ERA.

Healthcare providers can use the Humana ERA/EFT enrollment tool on the **Availity Essentials** provider portal. To access this tool:

1. Sign in to **Availity Essentials** (registration required).
2. From the Payer Spaces menu, select Humana.
3. From the Applications tab, select the ERA/EFT Enrollment app. (If you don't see the app, contact your Availity Essentials administrator to discuss your need for this tool.)

When you enroll in EFT, Humana claim payments are deposited directly in the bank accounts of your choice.

To learn more, call **Availity Essentials** or visit **Availity Essentials** online.

Submitting electronic transactions

To learn more about submitting electronic transactions, contact **Availity Essentials** or visit **Availity Essentials** online and choose Claims and Payments.

To submit a claim via **Availity Essentials**, sign in to Availity and choose Claims and Payments, then select Claims & Encounters.

For more information regarding electronic claim payment, contact **Humana Provider Services** or visit Humana's **provider claims and payments website**.

EDI clearinghouses

EDI is the computer-to-computer exchange of business data in standardized formats. Our EDI system complies with HIPAA standards for electronic claim submission, including transaction and code set format specifications.

Timely provider payments

Providers are required to file claims/encounters for all services rendered to members in a timely manner. Timely filing is an essential component reflected in Humana's HEDIS reporting and ultimately may impact 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.⁴¹ This includes the fiscal agent making payments to personal assistants under the HCBS waivers for covered services.

Payment complaints or disputes for the provision of services are subject to Humana's provider dispute process. For claim payment inquiries or complaints, please contact **Humana Provider Services**.

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.

Procedure and diagnosis code sets

Federal law establishes various standards for all covered transactions under HIPAA, including electronic medical claims. Those standards currently include these code sets:

- HCPCS, which includes:
 - CPT codes, **available from the American Medical Association (AMA)**
 - HCPCS Level II codes, **available from CMS**
- National Drug Codes (NDCs), **available from the U.S. Food and Drug Administration (FDA)**
- ICD-10-CM, **available from the Centers for Disease Control and Prevention**
- ICD-10, Procedure Coding System (ICD-10-PCS), **available from CMS**

Code sets also are typically available, in various media, from vendors licensed to publish them.

Please note: Humana also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plan organizations. Local or proprietary codes are no longer allowed.

Unlisted CPT/HCPCS codes

If a procedure is performed that cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:

- A full, detailed description of the service provided
- A report, such as an operative report or a plan of treatment

⁴¹ 42 USC § 1396(a)(37)(A); 215 ILCS 5/368a

- Other information that would assist in determining the service rendered

As an example, the code 84999 is an unlisted lab code that requires additional explanation.

Common errors and reasons for denial or rejection

Common reasons for rejected or denied claims include the following:

- Member not found
- Insured subscriber not found
- Member birthdate on the claim does not match that found in Humana's database
- Missing or incorrect information
- Providers submitting with incorrect NPI/ZIP code/taxonomy/address/NPI type
- Missing provider NPI/ZIP code/taxonomy
- Providers submitting encounters with zero-dollar values
- Rendering provider data missing for provider organizations
- Invalid HCPCS code submitted
- No authorization or referral found
- Billing/rendering/attending NPIs not enrolled/registered for Medicaid with the state

You can avoid these common errors by doing the following:

- Confirming that member information received and submitted is accurate and correct
- Ensuring that all required claim form fields are complete and accurate
- Obtaining proper authorization and/or referrals for services rendered
- Ensuring you have a valid Medicaid ID for the billing/rendering/attending NPIs and taxonomies
- Ensuring billed amounts are not zero dollar; You must submit billed charges

Code editing and payment policies

Humana processes accurate and complete provider claims in accordance with Humana's normal claims processing procedures, including **claim processing edits, claim payment policies** and applicable state and/or federal laws, rules and regulations. See the **coverage and claims section of Humana's provider website** for more information about claims processing procedures; this summary of changes to claims processing procedures is not intended to be an exhaustive list.

Such claims processing procedures include review of the interaction of various factors. The result of Humana's claims processing procedures is dependent on the factors reported on each claim. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures, but examples of the most commonly used factors include:

- The complexity of a service

- Whether a service is 1 of multiple same-day services such that the cost of the service to the provider is less than if the service had been provided on a different day. For example:
 - 2 or more surgeries performed the same day
 - 2 or more endoscopic procedures performed the same day
 - 2 or more therapy services performed the same day
- Whether a cosurgeon, assistant surgeon, surgical assistant or other provider who is billing independently is involved
- When a claim includes more than 1 claim line, whether any service is part of, or incidental to, the primary service that was provided, or if these services cannot be performed together
- Whether the service is reasonably expected to be provided for the diagnosis reported
- Whether a service was performed specifically for the member
- Whether services can be billed as a complete set of services under 1 billing code

Humana develops claims processing procedures in our sole discretion based on our review of correct coding initiatives, national benchmarks, industry standards and industry sources, such as the following, including any successors of the same:

- State regulations, manuals and other related guidance
- Federal and state laws, rules and regulations, including instructions published in the Federal Register
- National Uniform Billing Committee (NUBC) guidance, including the UB-04 Data Specifications manual
- American Medical Association's (AMA) CPT and associated AMA publications and services
- CMS HCPCS and associated CMS publications and services
- ICD
- AHA's Coding Clinic Guidelines
- Uniform Billing Editor
- APA's DSM and associated APA publications and services
- FDA guidance
- Medical and surgical specialty societies and associations
- Industry-standard UM criteria and/or care guidelines
- Our medical and pharmacy coverage policies
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published, peer-reviewed literature

Changes to any one of the sources may lead Humana to modify current or adopt new claims processing procedures.

These claims processing procedures may result in an adjustment or denial of reimbursement; a request for the submission of relevant medical records, prior to or after payment; or the recoupment

or refund request of a previous reimbursement. You can access additional information on **Humana's provider website**.

An adjustment in reimbursement as a result of claims processing procedures is not an indication that the service provided is a noncovered service. Providers can submit a dispute request for adjustments produced by these claims processing procedures by submitting a timely request to Humana. For additional information, refer to the **provider disputes section of this provider manual**.

Humana provides notification of upcoming code editing changes. We publish new **code editing rules** and our rationales for these changes on the first Friday of each month.

Medicare and other primary payer sources

In the Humana Dual Fully Integrated plan, 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.

Crossover claims

If a member has both Original Medicare and Medicaid coverage, providers should file claims in the appropriate manner with the regional Medicare intermediary/carrier, making sure the member's Medicaid number is included on the Medicare claim form. Once the Medicare intermediary/carrier has processed/paid its percentage of the approved charges, Original Medicare will electronically submit a crossover claim to the Medicaid fiscal intermediary that includes the coinsurance and/or deductible.

For Medicare Part C, also known as Medicare Advantage, providers should file claims to Medicaid once the Medicare Advantage plan's explanation of remittance or EOB is received.

Medicaid program rules generally require members to exhaust other insurance coverage, including group health, workers' compensation and no-fault medical payment coverage before claims are submitted to the Medicaid program. Humana will coordinate benefits and process as secondary whenever these other forms of coverage are available. When a provider is aware of other coverage, claims should be submitted to the primary payer for a payment determination before claims are submitted to Humana. Claims involving COB will not be processed until an EOP/EOB or EDI payment information file is received, indicating the amount the primary carrier processed. Claims indicating

that the primary carrier paid in full (i.e., zero-dollar balance) must still be submitted to Humana for processing due to regulatory requirements.

When a member has both a Humana Medicare Advantage and Humana plan, Humana will make every effort to enter the claim on both plans. If the claim is sent to the Humana Medicare Advantage plan, when the claim is completed, we will send that Humana Medicare Advantage claim disposition to the provider. We also will apply that claim to the Humana plan and coordinate it with the Humana Medicare Advantage plan and send out the final claim disposition.

The only exception to this is when Humana uses a delegated entity for a specific claim service for the Humana Medicare Advantage plan. In this scenario, the provider would then need to submit the claim with the disposition received by the delegated entity to the Humana plan using the Humana group number for adjudication.

If the claim is not copied over for any other reason, the provider must submit the claim and the Humana Medicare Advantage plan disposition to the Humana plan using the Humana group number on the claim.

When coordinating between distinct Medicare and Medicaid plans, providers should wait for the full disposition of the Medicaid claim and not pursue unpaid Medicare cost share from the member.

Claim status

You can track the progress of submitted claims through our provider portal, **Availity Essentials**. Claim status is updated daily and provides information on claims submitted in the previous 24 months.

Search by state Medicaid ID number, service dates or claim number. You can find the following claim information on the provider portal:

- Reason for payment or denial
- Check numbers and date
- Procedure/diagnostic code
- Claim payment date

Claim payments by Humana to providers are accompanied by an itemized accounting of the individual claims in the payment, including the member's name, the date of service, the procedure code, service units, the reimbursement amount and identification of the Humana entity.

Suspension of provider payments

A network provider's claim payments are subject to suspension when the state determines that there is a credible allegation of fraud and notifies Humana.

Provider-preventable conditions/never events

Humana will not make payment on claims that have been identified to include provider-preventable conditions, also known as never events. If payment is made prior to the identification of the

provider- preventable condition, payment will be recovered by Humana through its overpayment recovery process.

Providers are required to report provider-preventable and healthcare-acquired conditions associated with claims for payment or member treatments for which payment would otherwise be made. Claims indicating these conditions are not to be paid. If not submitting a claim, providers must report the condition in writing to the state within timeline of occurrence.

Prepayment reviews

You have 30 days to submit documents in support of claims under prepayment review. Humana denies claims for which the requested documentation was not received by day 46. Humana denies claims when the submitted documentation lacks evidence to support the service or code. Humana follows state guidelines for any appeals related to the prepayment process. In-network providers have 18 months and out-of-network providers have 180 days to submit an appeal. Humana may extend the length of a prepayment review when it is determined necessary to prevent improper payments.

Claims processing when member health plan or coverage changes

From Humana to another plan

In the event of a member's termination of enrollment with Humana and subsequent enrollment into a different D-SNP plan, Humana may submit voided encounters to Illinois and notify providers of adjusted claims. Humana may recoup payments for fraud at any time and for all other reasons within 18 months. After providing a notice of recoupment, Humana recoups the payment within 60 days.

From another plan to Humana

If a member was previously enrolled with another Medicaid plan and is now eligible with Humana, providers are required to submit a copy of the EOP reflecting recoupment of payment and documentation from the previous MCE to validate the original encounter has been voided and accepted by Illinois.

These items are used to support overriding timely filing, if eligible. If a claim has exceeded timely filing due to retroeligibility from another Medicaid plan, you have 60 days from the date of the accepted voided encounter to submit the claim to Humana to avoid untimely filing denials.

Out-of-network claims

Humana requires authorization for out-of-network care for non-self-referral or nonemergent services except as otherwise noted, based on medical necessity, when a network provider is not available to provide members with medically necessary covered services in a timely manner.

Authorization requests must be submitted via **Availity Essentials** for members to receive out-of-network services.

With some exceptions, these services will be reimbursed at a negotiated rate, or in the absence of a negotiated rate, an amount not less than 100% of the Medicaid fee-for-service rate. Out-of-network emergency services will be reimbursed at 100% of the Medicaid rate unless other payment arrangements are made.

Coordination of benefits

Humana collects COB information for our members. This information helps us ensure we pay claims appropriately and comply with federal regulations that Medicaid programs are the payer of last resort.

While we try to maintain accurate information at all times, we rely on numerous sources for information updated periodically, and some updates may not always be fully reflected on **Availity Essentials**. Humana will pay up to the Medicaid allowable limit under the appropriate payment schedule minus any other insurance paid amounts.

If the member responsibility amount from the other carrier is less than the difference between the Medicaid allowable limit and the other insurance paid, it will pay the other carrier member responsibility amount.

- COB requires a copy of the appropriate remittance statement from the primary carrier.
 - Electronic and paper claims
 - Primary carrier's payment information
 - EOB from primary carrier
- If a claim is denied for COB information needed, you must submit the appropriate remittance statement from the primary payer within the remainder of the initial claim timely filing period.

Third-party liability

Humana's plans allow claims for healthcare services provided due to automobile and workplace injuries according to applicable Medicare Secondary Payer (MSP) and state Medicaid agency requirements.

However, you must make all reasonable efforts to determine whether there is other coverage for an automobile or workplace injury, such as under automobile or workers' compensation insurance, and must promptly report as described below, in claims submitted to Humana and to any such other coverage that is identified.

Additionally, you must bill a member's first party medical payments coverage (MPC) or personal injury protection (PIP) automobile insurance or workplace injury insurance plan, if applicable, before billing the member's Humana plan. Finally, you must promptly forward to Humana any determination by an automobile or workplace insurance plan made with respect to a claim for a Humana member's injury. Your failure to promptly fulfill any requirement could affect Humana's disposition of a claim after initial receipt and/or after initial adjudication.

Medicare and Medicaid are the payers of last resort unless the probable existence of third-party liability cannot be established or third-party benefits are not available to pay the member's medical

expenses at the time the claim is filed. If either of those scenarios happen, Humana will first pay the provider and will seek reimbursement from the possibly liable third party.

Automobile insurance

If you identify automobile insurance, you must include the information below when submitting a paper claim to Humana or equivalent information when submitting an electronic claim to Humana.

CMS-1500 or electronic equivalent	For UB-04 or electronic equivalent
• Enter “yes” in box 10-B. • Enter the accident date in field 14. • Enter all diagnosis codes in section 21. • Attach the following to the claim, if available: – Copy of the check from the primary insurance carrier – Copy of the EOB from the primary insurance carrier – Copy of the exhaustion denial letter from the primary insurance carrier – Statement from the member indicating no PIP coverage, if applicable	• Enter occurrence code 01 or 02, as applicable, and the accident date in fields 33-35. • Enter value code 14 in fields 39-41. • Enter all diagnosis codes in fields 67-76. • Attach the following to the claim, if available: – Copy of the check from the primary insurance carrier – Copy of the EOB from the primary insurance carrier – Copy of the exhaustion denial letter from the primary insurance carrier – Statement from the member indicating no PIP coverage, if applicable

Workers' compensation insurance

If a provider identifies workers' compensation insurance, the provider must include the information below when submitting a paper claim to Humana or equivalent information when submitting an electronic claim to Humana.

CMS-1500 or electronic equivalent	For UB-04 or electronic equivalent
• Enter “yes” in box 10-B. • Enter the accident date in field 14. • Enter all diagnosis codes in section 21. • Attach the following to the claim, if available: – Copy of the check from the primary insurance carrier – Copy of the EOB from the primary insurance carrier – Copy of the exhaustion denial letter from the primary insurance carrier – Statement from the member confirming that the member’s employer does not provide workers’ compensation coverage	• Enter occurrence code 04 and accident date in fields 33-35. • Enter condition code 02, 05 or 77, as applicable, in fields 18-28. • Enter value code 15 or 41, as applicable, in fields 39-41. • Attach the following to the claim, if available: – Copy of the check from the primary insurance carrier – Copy of the EOB from the primary insurance carrier – Copy of the exhaustion denial letter from the primary insurance carrier – Statement from the member confirming that the member’s employer does not provide workers’ compensation coverage

COB overpayment

When you receive a payment from another carrier after receiving payment from Humana for the same items or services, we consider this an overpayment. Humana provides written notice to you at least 30 business days before an adjustment for overpayment is made. If a dispute is not received from you, adjustments to the overpayment are made on a subsequent reimbursement.

Providers can issue refund checks to Humana for overpayments and mail them to **COB overpayment**.

Providers should not refund money paid to a member by a third party.

When Humana is aware of other insurance coverage prior to paying for a claim, the claim will be denied, indicating that the claim should first be submitted to the appropriate third party. Humana will ensure that this does not prevent a member from receiving medically necessary services in a timely manner. If Humana is unable to establish that a member has other insurance, Humana will pay the claim and then pursue reimbursement from the potentially liable third party within 60 calendar days after the end of the month in which we paid.

If a member retroactively becomes Medicare eligible, Humana will recover for medical expenses payable by Medicare for the months of retroactive Medicare eligibility.

Humana will engage in efforts for 2 years from the date of service to determine if a member had commercial insurance that was not known at the time of payment. Humana will not require providers to be involved or recoup payments from providers unless the provider was paid in full by both Humana and commercial insurance.

- COB requires a copy of the appropriate remittance statement from the primary carrier.
 - Electronic and paper claims

- Primary carrier's payment information
- EOB from primary carrier
- If a claim is denied for COB information needed, the provider must submit the appropriate remittance statement from the primary payer within the remainder of the initial claim timely filing period.

If a provider identifies any overpayments, it is the provider's responsibility to report and refund the overpayment⁵⁶ within 60 days of its initial identification. In addition, the provider must furnish Humana with a written reason for the overpayment (e.g., excess payment under COB).

Member billing

State requirements and federal regulations prohibit providers from billing Humana Dual Fully Integrated members for medically necessary covered services except under extremely limited circumstances. Providers who knowingly and willfully bill a member for a Medicaid-covered service are guilty of a felony and on conviction are fined, imprisoned or both⁵⁷. Members cannot be billed and will be held harmless for services that are administratively denied. The only exception is if a Humana Dual Fully Integrated member agrees in advance, in writing, to pay for a non-Medicaid-covered service. This agreement must be completed prior to providing the service, and the member must sign and date the agreement acknowledging member financial responsibility.

Providers can bill a member for covered services when PA is denied and all of the following conditions have been met in the following order:

1. Authorization has been requested and denied prior to rendering the service.
2. The provider has requested a review of the denial decision, or the time period for requesting such review has passed.
3. If the decision is maintained, the provider must inform the member that the service requires authorization and has been denied. For out-of-network providers, the member must also be informed that covered services may be authorized for an in-network provider without cost.
4. The provider must inform the member of the member's responsibility for payment if the member still chooses to receive the services without authorization.
5. If the provider chooses to use a waiver to document the member's responsibility for payment, the waiver must:
 - a. Be signed by the member only after the member has been notified
 - b. Be obtained for each patient visit or encounter for noncovered services
6. § 6402(a) of the Patient Protection and Affordable Care
7. As defined in the SSA
 - c. Specify the dates of service and identify the services to which the waiver applies
 - d. Not contain any conditional language to the effect that a denied authorization indicates the member is responsible for payment

8. Member must be informed of the right to contact Humana to file an appeal if the member disagrees with the PA denial. Please refer to the **member grievance and appeals chapter of this provider manual** for more details.
9. The provider must have the right to appeal any denial of payment by Humana for denial of authorization.

If the member attempts to receive a noncovered service, providers must inform the member the cost of the service and how much they may be billed prior to providing the service. Please refer to the **PA section of this provider manual** for more details.

Providers should call **Humana Provider Services** for guidance before billing members for services.

Provider claim disputes

If you disagree with the initial claim determination made by Humana, you may request a dispute/reopening of the issue. You may submit disputes online through **Availity Essentials** or by contacting us via telephone, written correspondence or fax as outlined below.

Step 1:

Call **800-787-3311**, Monday through Friday, 7 a.m. – 7 p.m., Central time.

- Have the claim reference number handy.
- Note the call reference number issued to you by the provider call center representative as it may be needed in the future.
- If your issue is still outstanding and has not been adequately addressed by the call center representative, you have the option to speak to a call center supervisor. Based on availability, you will be connected to a supervisor, or a supervisor will contact you within 48 hours of your request.

or

Submit a written claim dispute via:

Mail: Humana Provider Correspondence

P.O. Box 14359

Lexington, KY 40512-4359

Fax: **888-599-2730**

When submitting a written claim dispute, include a copy of the original claim, the remittance notification showing the denial, and any clinical records or other documentation that support your case for reimbursement.

Step 2:

If we respond to your initial inquiry and there is a factual disagreement with the response, you can send a secured email (with the reference number) to **HumanaProviderServices@humana.com**.

Note: The reference number received from Step 1 must be included in the request to Humana Provider Services.

For more information, please visit **Humana's Claim-Payment Inquiries webpage**. You will receive regular updates about your inquiry after you send an email to **HumanaProviderServices@humana.com**.

Provider claim disputes for behavioral health claims

Behavioral health providers may submit disputes by phone, email or fax.

- **Phone: 844-231-7949**
- **Email: WoburnClaimAppeals@carelon.com**
- **Fax: 781-994-7636**

Disputes submitted by 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 upon request.

Chapter 13: Complaints, grievances and disputes

Contact information pertaining to complaints, grievances and disputes

Contact name	Contact information	Hours of operation
Carelon Provider Services	Phone: 855-481-7044 Fax: 305-722-3013 Email: WoburnClaimAppeals@carelon.com	Monday through Friday, 7 a.m. to 5 p.m., Central time
Grievances and Appeals department	Mail: Humana Attn: Grievances and Appeals Department P.O. Box 14163 Lexington, KY 40512-4163	
Humana Provider Services	Phone: 800-787-3311 (TTY: 711)	Monday through Friday, 7 a.m. to 7 p.m., Central time
Nonbehavioral health provider disputes	Phone: 800-787-3311 Mail: Humana Provider Correspondence P.O. Box 14359 Lexington, KY 40512-4359 Fax: 888-599-2730 Online: Availity Essentials	Monday through Friday, 7 a.m. to 7 p.m., Central time

Overview

Humana's policies and procedures for complaints, grievances, disputes and appeals are aligned with the Code of Federal Regulations.

You have the right to file a grievance or appeal with Humana regarding a healthcare service, claim for reimbursement, provider payment or a contractual issue.

A grievance is a complaint. An appeal is a request to review a previous decision made by Humana to deny, suspend or terminate the services.

For purposes of this section, a coverage denial is Humana's determination that a treatment or service is specifically limited or excluded under the member's specified health benefit plan. When a coverage denial is involved, you may request an internal appeal.

You can file grievances and appeals on your own behalf. You can file an appeal on behalf of a member if you have the member's written consent. Humana ensures no punitive or retaliatory action is taken against a member or provider who files a grievance or appeal or a provider who supports a member's grievance or appeal.

Process and timelines

All inquiries, complaints, grievances and disputes should be directed to **Humana Provider Services**. Based on the type of issue or complaint, your inquiry will be reviewed by a Humana associate with the designated authority to resolve your issue or complaint.

Your complaint, grievance or dispute may be filed verbally or in writing.

Provider disputes

If after receipt of an initial claim determination from Humana via explanation of remittance, automated RA or RA, you disagree with Humana's determination, you may request a dispute (reopening) of the issue.

Nonbehavioral health provider disputes

Nonbehavioral providers may submit their disputes online, by telephone, mail or fax. Please refer to **nonbehavioral health provider disputes** for contact information.

Online	Telephone	Mail	Fax
Provider disputes about finalized claims can be submitted online via Availity Essentials .	Provider disputes may be filed by calling nonbehavioral health provider disputes . Follow the prompts to provide the claim ID for the disputed claim, then request to file a claim dispute. You will be transferred to an associate who can assist you.	Written disputes can be mailed to nonbehavioral health provider disputes via Humana Provider Correspondence.	Provider disputes may be submitted via fax.

When submitting a dispute online using **Availity Essentials**, 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, please refer to the **provider web-based training and resources website**.

What to include in your dispute

Provider disputes containing as 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

Dispute tracking

We are required to assign you an 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.

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 is required to assign a Managed Care Organization (MCO) Tracking Number for each complaint submitted through its internal provider dispute process. For non-behavioral health disputes, this tracking number is a 12 – 13 character alphanumeric code that uniquely identifies the complaint. Please allow 2 – 3 business days for a tracking number to be generated when a dispute is submitted via fax. If you are unable to locate an MCO Tracking Number, wait until this timeframe has passed before contacting Humana, as this allows for necessary system processing and number generation.

You can also refer to the outcome letter we send in response to your claim dispute. The MCO tracking number is identified as Reference ID in the header of the outcome letter.

Behavioral health provider disputes

Behavioral health providers may submit their disputes by phone, mail or fax by contacting Carelon. Please refer to the contact information table at the beginning of this chapter for Carelon's contact information.

Telephone	Email	Fax
Provider disputes can be submitted directly to Carelon Provider Services via phone.	Provider disputes and supporting documentation may also be submitted via email.	Provider disputes and supporting documentation may also be submitted via fax.

Disputes submitted by 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 upon request.

Carelon Provider Services will respond to the submitting provider with the MCO tracking number for disputes received via email.

Carelon Provider Services will call the submitting provider with the MCO tracking number for disputes received by fax that include a phone number. If a phone number was not included, a fax will be sent acknowledging receipt of the dispute and will include the MCO tracking number.

The reference number for behavioral health provider disputes includes 15 numbers, separated by a dash after the 8th 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**. Once your case is located, the provider services representative will give you the MCO tracking number.

You can also refer to the outcome letter we send in response to your claim dispute. The MCO tracking number is identified as Reference ID in the header of the outcome letter.

Provider disputes submitted to the Illinois HFS

You may submit complaints regarding unresolved issues with Humana via the **Managed Care Provider Resolution Portal**. Humana is responsible for the timely and complete resolution of provider complaint tickets uploaded to the portal.

Disputes cannot be submitted through the **Managed Care Provider Resolution Portal**:

- Earlier than 30 calendar days after submitting the complaint to Humana
- Any later than 30 calendar days after unsatisfactory resolution
- Any later than 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 (please refer to the **provider disputes section of this provider manual for more information**). If applicable, include the date you received the MCO resolution. The Illinois HFS will share 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 **Managed Care Provider Resolution 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 single template. When submitting the 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 furnish 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 **Managed Care Provider Resolution Portal**. Incomplete complaints or lack of response from the provider will result in the complaint being closed in the **Managed Care Provider Resolution Portal**.

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

Member grievances and appeals system

Information about member grievances and appeals is provided to you so that you may assist Humana members in this process, should they request it. You can also refer members to their **member handbook** or you may reach out to **Humana Provider Services** for more information about this process.

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

Filing a grievance or appeal

If members have questions or issues, please refer them to **Humana Provider Services**. 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.

Member 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 requested outcome
- Requestor's signature and date
 - If the requestor is not the member, additional documentation such as a waiver or appointment of representative form may be required.

Grievance	Appeal
Members have a right to file a written or verbal grievance at any time.	Members have a right to file a written or verbal appeal within 65 calendar days of the date on the denial letter.
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.	The appeal process takes no more than 14 calendar days, but Humana resolves the appeal as quickly as the member's health condition requires.
A letter advising the grievance outcome is sent to the member or their authorized representative within 30 calendar days from the date Humana received the request.	A letter advising the appeal outcome is sent to the member or their authorized representative within 14 calendar days of the date Humana received the request.

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

The member has the right to continue receiving services during the appeal and State 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 State Fair Hearing.

Providers appealing a claim on behalf of a member may also do so online via **Availity Essentials**. To do so, use the Claim Status tool to locate the claim and select Dispute Claim. Then, navigate to the request in the Appeals worklist (located under Claims & Payments) to supply the necessary information and documentation and submit the request to Humana. You can then view the appeal status and high-level Humana determination for appeals submitted online in the Appeals worklist.

To review and complete available training related to **Availity Essentials**, please refer to our **provider web-based training and resources website**.

Expedited appeal process

The member, provider or authorized representative can request a verbal or written expedited appeal.

If the member's life or health is in danger, the member or their authorized representative can file an urgent or expedited appeal. These appeals are handled within 24 hours of receipt of all the information required to work the appeal. You can request an expedited appeal by calling **Humana Provider Services**. If it is determined the appeal does not meet expedited criteria, it will then be sent through the standard appeal process. Grievances and appeals requested in writing can be mailed to the **Grievances and Appeals department**.

Chapter 14: Credentialing and recredentialing

Contact information pertaining to credentialing and recredentialing

Contact name	Contact information	Hours of operation
Humana Provider Services	Phone: 800-787-3311 (TTY: 711)	Monday through Friday, 7 a.m. to 7 p.m., Central time

Overview

Provider credentialing is the process of reviewing the qualifications and appropriateness of a provider to join Humana's network. Humana conducts credentialing and recredentialing activities utilizing the guidelines established by the NCQA as required by the state. Humana credentials and recredentials all licensed, independent practitioners including providers, nonproviders and organizational providers with whom it contracts and who fall within its scope of authority and action. A senior clinical staff person is responsible for oversight of the credentialing and recredentialing program.

All practitioners requiring credentials should complete the credentialing process prior to appearing in the provider directory. All credentials must be current at the time of the credentialing committee decision. Humana completely processes credentialing applications from all provider types within 30 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments.

Provider recruitment and nondiscriminatory credentialing policy

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

As part of this process, Humana collects and publishes spoken languages in our **Physician Finder** provider directory. Please be sure to accurately indicate all languages spoken in your offices on your Humana recredentialing application and/or CAQH application or contact **Provider Services** to request updates.

Humana gathers information on the languages in which healthcare providers are fluent, particularly concerning their ability to communicate medical care effectively. This includes details about any language services offered through the practice. Additionally, Humana gathers data on race, language skills and ethnicity of providers. Providing this information is entirely voluntary.

Request to join the network

All provider types may submit a request to join the network by signing in to the Humana Provider Portal in Quickbase (registration required). To join, go to **Humana’s Join Our Network website** and select **online form**. Failure to submit a complete application may result in a delay in our ability to complete or begin the credentialing process. Practitioners are notified within 3 business days in the event it is determined the request to join the network is incomplete.

Behavioral health providers contracted by Carelon should visit **Humana’s Join Our Network website | Carelon Behavioral Health** to join Carelon’s network.

IMPACT enrollment

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 the **IMPACT website**.

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 the **IMPACT website**.

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

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 Humana Dual Fully Integrated 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**.

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.

Credentialing process by provider type

Individual practitioners

CAQH application for providers

Humana is a participating organization with the Council for Affordable Quality Healthcare® (CAQH). You can confirm we have access to your credentialing application by completing the following steps:

1. Sign in to the **CAQH website** using your account information (registration required).
2. Select the Authorization tab.
3. Confirm Humana is listed as an authorized health plan. If it is not listed as an authorized health plan, please select the checkbox to add it.

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

Be sure to include your CAQH provider ID number when submitting credentialing documents. It is essential that all documents are complete and current. Please include copies of the following documents:

- Current Malpractice Insurance Face Sheet
- A current DEA certificate
- All buprenorphine prescribers must have an “X” DEA number
- Explanation of any lapse in work history of 6 or more months
- CLIA certificate, as applicable
- ECFMG, if you have a foreign medical degree
- If you are acting as a PCP, attestation that your total member load is not more than 3,000 members
- Disclosure of Ownership, as applicable

mEvaluation of practitioners included within the scope of credentialing for the Humana Dual Fully Integrated network include the following:

Physical health practitioners	Behavioral health practitioners
Providers	Psychiatrists and other providers LCACs
Oral surgeons	Doctoral or master's level psychologists who are state licensed
Chiropractors	HSPPs
Podiatrists	Licensed, independent practice school psychologists
Dentists	Master's level clinical social workers who are state licensed
Optometrists	Master's level clinical nurse specialists or psychiatric nurse practitioners who are state licensed
Allied health providers, including:	Master's level licensed marriage and family therapists who are state licensed
Advanced practice registered nurses	Master's level mental health counselors (LMHCs) who are state licensed
Clinical nurse specialists	ABA therapists
Certified nurse midwives	Other behavioral health specialists who may be within the scope of credentialing and are licensed by the state to practice independently or as required by state regulations
Physician assistants	
Therapists, including:	
Speech and speech/language pathologists	
Occupational	
Physical	
Audiologists	
Other licensed or certified practitioners, including provider extenders who act as a PCP or those that appear in the provider directory	

Practitioner enrollment application

Please see the [how to join our network section of this provider manual](#).

Credentialing application

A signed and dated CAQH credentialing application, including supporting documents and signature not more than 120 calendar days old, is required.

Licensure

An unrestricted license in the practicing state issued by the licensing board is required.

Drug Enforcement Administration and a controlled substance registration

The following are required:

- Unrestricted DEA in the practicing state, as applicable
- Unrestricted controlled substance registration (CSR) certificate issued by the state pharmaceutical licensing agency, as applicable.

If the practitioner states in writing the practitioner does not prescribe controlled substances and that in the practitioner's professional judgment, the members receiving care do not require controlled substances, the practitioner is not required to have a DEA/CSR certificate but must describe the practitioner's process of handling instances when a member requires a controlled substance.

Education and training

Successful completion of all training programs pertinent to one's practice:

Medical doctors and doctors of osteopathy	Doctors of chiropractic medicine	Doctors of podiatric medicine	Advanced Practice Registered Nurses	Provider assistants	Dentists and other providers
Successful completion of residency training pertinent to the requested practice type	Proof from a chiropractic college for doctor of chiropractic medicine	Proof of graduation from podiatry school and completion of residency program for doctors of podiatric medicine	Proof of graduation from an accredited master's degree program	Proof of graduation from an accredited master's degree program	Successful completion of training program

Board certification

Proof of board certification if the practitioner's application states the practitioner is board-certified is required.

Admitting privileges

The following are required:

- The practitioner holds current clinical privileges in good standing at a participating facility, as applicable.
- If the provider does not hold admitting privileges, an explanation of admitting arrangements applicable to the care the practitioner provides is required.

Work history

The following are required:

- Work history that includes a minimum of 5 years via curriculum vitae (CV) or included on the application
- Gaps of 6 months or more to be explained

Malpractice insurance

The following is required:

- Current malpractice insurance coverage at the minimum amount in accordance with state laws in which the practitioner provides care

Malpractice history

The following is required:

- Explanation detailing any pending professional liability claims and claims resulting in settlements or judgments paid by or on behalf of the practitioner

NPI

- The NPI must be verifiable via the National Plan and Provider Enumeration System (NPES).

Site visit

The following are required:

- PCP office locations must be surveyed prior to being credentialed.
- PCP and high-volume specialist office locations must be surveyed prior to being recredentialed.

Practitioners that may serve as a PCP include the following: internal medicine providers, general practitioners, family medicine providers, gynecologists, endocrinologists/internal medicine, geriatricians, advanced practice registered nurses and physician assistants. Providers that serve as high-volume specialists include the following: cardiology/cardiovascular disease, ophthalmology, oncology/medical oncology, orthopedic surgery and gastroenterology.

In good standing with regulatory agencies

The following are required:

- Provider, or an agent or managing employee of the provider, is in good standing with and not debarred, suspended or otherwise excluded by federal, state or local agencies including:
 - Medicaid agencies, including:
 - State Termination of Provider Participation in Medicaid and Children's Health Insurance Program (CHIP) list
 - Medicare intermediary, including:
 - ◆ CMS Medicare preclusion list
 - ◆ CMS opt-out list
 - ◆ Health and Human Services Office of Inspector General (HHS-OIG)
 - ◆ General Services Administration (GSA, formerly Excluded Parties List System [EPLS])
 - ◆ State sanctions and restrictions on licensure

Performance indicators

For recredentialing purposes only, the practitioner should demonstrate an acceptable performance record related to Humana members with no evidence of quality issues.

Demographics

Verify practitioners are appropriately linked to groups, as applicable, and that practitioners are enrolled at the appropriate service locations.

Common practitioner credentialing mistakes

Need	Most common mistakes	Recommendation
CAQH application	Your CAQH application status is incomplete or expired. We do not have authorization to access your CAQH application. Information in your completed CAQH profile is expired or outdated. For example, confirm the following information is up to date: • Practice information • Credentialing contact • Malpractice insurance coverage face sheet including your name, coverage amounts, and effective and expiration dates	The information on CAQH must match the information you provide on your network participation request. Ensure your CAQH application is up to date before requesting to join the network.
Supporting documents	The incorrect document is provided. The document is expired or will expire within the next 30 calendar days.	Provide all the correct and completed documents as required.
Response time for requested documentation	There is a slow response time to requested information.	Missing or incomplete documents are signed and returned as quickly as possible.

Organizational/ancillary provider credentialing

Organizational providers evaluated within the scope of credentialing for the Humana Dual Fully Integrated network include the following:

- Behavioral health facilities providing mental health or substance abuse services in an IP, residential or ambulatory setting
- Diabetes education
- Dialysis centers

- FQHCs
- Free-standing ASCs
- Free-standing birthing centers
- Home health agencies
- Hospice providers
- Hospitals
- Pharmacies
- PT/OT/SLP facilities
- Portable X-ray suppliers
- Rehabilitation hospitals (including outpatient locations)
- RHCs
- SNFs
- Urgent care clinics

Behavioral health facilities providing mental health or substance use services in the following settings are also assessed:

- IP
- Residential/extended care facilities
- Ambulatory

A completed facility enrollment form, including supporting documents, is necessary to assess an organization for network participation. A completed facility enrollment form must include the following:

- A completed roster, dependent on provider type
 - A complete FQHC/RHC roster template for FQHCs/RHCs
 - A complete organizational provider roster template for all other provider types
- An active Medicaid ID
- A Behavioral Health Profiling form for providers offering behavioral health services
- A copy of the following supporting documentation attached to the facility enrollment form:
 - The facility's license, as applicable
 - Accreditation letter, as applicable
 - CMS certification, as applicable
 - Malpractice insurance policy face sheet indicating effective and expiration dates and limits of liability within amounts at the minimum in accordance with state laws in which the organization provides care
 - CLIA, as applicable

- Disclosure of ownership form
- W-9 tax form

Failure to submit a complete application will cause a delay in our ability to begin or complete the credentialing process. Facilities will be notified within 5 business days if we determine the request to join the network is incomplete.

Facility enrollment form

Completion of a signed and dated application, signature not more than 120 calendar days old is required.

Licensure/business license/permit, as applicable

As required by state, federal and local regulatory bodies, the provider is currently licensed. Providers requiring licensure must be in good standing with the appropriate licensing board.

Insurance coverage

Current general/comprehensive/malpractice liability insurance coverage or participation in the federal tort program as applicable per state requirements is required.

Eligible for Medicaid

The organization, or an agent or managing employee of the provider, is in good standing and not debarred, suspended or otherwise excluded by federal, state and local agencies including:

- Currently enrolled and has an active provider Medicaid ID number
- Must not be sanctioned, excluded or debarred from participation in any Medicaid program
- Must not appear on the state Termination of Provider Participation in Medicaid and CHIP list

Eligible for Medicare

The organization, or an agent or managing employee of the organization, is in good standing with and not debarred, suspended or otherwise excluded by federal, state and local agencies including:

- Must not be sanctioned, excluded or debarred from participation in Medicare
- Verification that the provider has not opted out of participation with Medicare
- Verification that the provider does not appear on the CMS preclusion list
- Must be Medicare-certified; Humana will verify an organizational provider's Medicare certification status

Free from sanctions, exclusion or debarment

The organization, or an agent or managing employee of the organization, is in good standing with and not debarred, suspended or otherwise excluded by federal, state and local agencies including:

- Verification that the provider has not been sanctioned, excluded or debarred by the OIG, the System for Award Management (SAM) or any other disciplinary action by any federal, state or local entity identified by CMS

CLIA

Verification that all independent laboratories and organizations billing for lab services meet CLIA regulations⁴² is required.

On-site quality assessment

The provider must supply evidence an on-site quality assessment has been conducted, as applicable:

- **Accreditation body:** The organizational provider must supply a copy of the accreditation report or evidence from an accreditation body where the provider is accredited.
- **CMS or state quality review:** If an organizational provider is not accredited, Humana may substitute a CMS or state review in lieu of performing its own on-site quality assessment. Humana verifies that an on-site quality assessment has been completed by a state agency or CMS by obtaining the assessment report or certification letter. The CMS or state review may not be more than 3 years old at the time of verification.
- **Quality review conducted by Humana:** If the CMS or state review is older than 3 years, Humana conducts its own on-site quality review. If the state or CMS has not conducted a site review of the provider and the provider is in a rural area (as defined by the U.S. Census Bureau), Humana may choose not to conduct a site visit.

NPI

NPI must be verifiable via NPPEs.

⁴² 42 C.F.R. § 493.1809

Opioid treatment program providers

In addition to the requirements listed above, OTP providers must provide:

- Evidence of active DEA certification
- Evidence of certification from the Division of Mental Health and Addiction (DMHA) as an OTP

SUD addiction treatment providers

In addition to the requirements listed above, SUD providers must:

- Provide evidence of ASAM level of care
- Provide evidence of certification from the DMHA level-of-care designation
- Be an entity, not an individual
- Have a primary physical address/location

SUD residential treatment facilities located outside the state of Illinois may apply.

- Documentation required for new provider credentialing:
 - Facility enrollment form (must be current and signature date will not expire within the next 30 calendar days)
 - Behavioral Health Profiling form
- Facilities that have ASAM residential level-of-care designations must include both designations on the Behavioral Health Profiling form.
 - Illinois Medicaid provider ID
 - Copy of certification form (must be current and will not expire within the next 30 calendar days)
- Copy of DMHA certification as a sub-acute facility that includes ASAM level-of-care designation 3.1 or 3.5 residential services
- Proof of Department of Child Services licensing as a childcare institution or private secure-care institution with a DMHA addiction services provider regular certification that includes ASAM level-of-care designation 3.1 or 3.5 residential services
 - Copy of DEA registration certificate
 - CMS/Medicare certification letter, if certified
 - Accreditation letter from an approved entity:
- The Joint Commission
- Council on Accreditation
- Commission on Accreditation of Rehabilitation Facilities
 - Malpractice insurance face sheet showing effective and expiration dates and limits of liability coverage
 - CLIA certificate, if applicable (must be current and will not expire within the next 30 calendar days). CLIA address must match the address on the application

Disclosure of ownership

The following are required:

- Disclosure Form CMS 1513
- Humana disclosure of ownership, business transactions and exclusions statement for providers

Common organizational/ancillary provider credentialing mistakes

Need	Most common mistakes	Recommendation
HCBS/LTSS assessment application	The facility enrollment form is incomplete or expired.	Ensure the facility enrollment form is up to date before requesting to join the network.
Supporting documents	The required supporting documents are missing. The document is expired or will expire within the next 30 calendar days.	Provide all the correct and completed documents as required.
Response time for requested documentation	There is a slow response time to requested information.	Missing or incomplete documents are signed and returned as quickly as possible.

HCBS/LTSS provider credentialing

HCBS providers evaluated within the scope of certification for the Humana Dual Fully Integrated network include the following:

- Adult day care
- Adult family home/community home share
- Assisted living facility
- Attendant care
- Community transportation
- Home and community assistance
- Home-delivered meals
- Home modifications
- Integrated healthcare coordination
- Nutritional supplements
- PERS
- Pest control
- Respite
- Specialized medical equipment

- Structured family care
- Vehicle modification

A complete HCBS/LTSS provider assessment application, including supporting documents, is necessary to assess an HCBS provider for network participation. A completed HCBS/LTSS provider assessment application must include the following:

- An HCBS/LTSS provider assessment application attestation signature date not more than 120 calendar days old
- An active Medicaid ID
- Disclosure of ownership form
- W-9 tax form
- HCBS certification from the Illinois Department on Aging

The following elements are evaluated when certifying and recertifying HCBS providers:

- Completion of a signed and dated HCBS/LTSS assessment application
- Signature not more than 120 calendar days old

State certification

HCBS providers must be certified by the Illinois Department on Aging.

Eligible for Medicaid

The HCBS or LTSS provider, or an agent or managing employee of the provider, is in good standing with, and not debarred, suspended or otherwise excluded by federal, state or local agencies. The provider:

- Is currently enrolled and has an active provider Medicaid ID number
- Must not be sanctioned, excluded or debarred from participation in any Medicaid program
- Does not appear on the state Termination of Provider Participation in Medicaid and CHIP list

Free from sanctions, exclusion or debarment

The organization, or an agent or managing employee of the organization, is in good standing with and not debarred, suspended or otherwise excluded by federal agencies.

Verification that the provider has not been sanctioned, excluded or debarred by the OIG, SAM or any other disciplinary action by any federal, state or local entity identified by CMS is required.

NPI

NPI must be verifiable via NPES.

Common HCBS/LTSS provider credentialing mistakes

Need	Most common mistakes	Recommendation
HCBS/LTSS assessment application	The HCBS/LTSS provider assessment application is incomplete or expired.	Ensure the assessment application is up to date before requesting to join the network.
Supporting documents	Certification from the Department on Aging is missing. The document is expired or will expire within the next 30 calendar days.	Provide all the correct and completed documents as required.
Response time for requested documentation	There is a slow response time to requested information.	Missing or incomplete documents are signed and returned as quickly as possible.

Note: Atypical providers, such as waiver providers, are not required to have an NPI. If an atypical provider does not have an NPI, a Medicaid provider ID is required in lieu of an NPI.

Additional documentation and enrollment status

If you need to submit additional documents or would like to check the enrollment status, medical providers can reach out to **Humana Provider Services**. Failure to submit a complete application will delay the enrollment process with Humana. HCBS providers are notified within 5 business days in the event it is determined the request to join the network is incomplete.

Failure to submit a complete application may result in a delay in Humana's ability to complete or begin the credentialing process. You can confirm Humana's access to your credentialing application by completing the following steps:

1. Sign in to the **CAQH website** using your account information (registration required).
2. Select the Authorization tab.
3. Confirm Humana is listed as an authorized health plan. If it is not listed as an authorized health plan, please select the checkbox to add it.

Recredentialing process

Network providers, including practitioners, organizational and LTSS providers, are recredentialed at least every 3 years. As part of the recredentialing process, Humana considers information regarding performance to include complaints and safety and quality issues collected through the QI program. Additionally, information regarding adverse actions is collected from the NPDB, Medicare and Medicaid Sanctions, CMS Preclusion list, the HHS/OIG and GSA (formerly EPLS), and limitations on licensure. A notification will be sent to you for reverification of credentialing. All

network providers must submit updated documents as they expire. Failure to provide updated documentation may delay payment. Your contract may be terminated at any time if it is determined the credentialing requirements are no longer being met or you fail to complete the recredentialing process.

Provider rights and responsibilities in credentialing process

Provider rights

You have the right to review, on request, information submitted to support the credentialing application to the Humana Credentialing Operations department. Humana keeps all submitted information secure and confidential.

Access to electronic credentialing information is password-protected and limited to staff that require access for business purposes.

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

Providers have the right to be informed of the status of their credentialing/certification or recredentialing/recertification application on written request to the Credentialing Operations department.

Provider responsibilities

Network providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. Humana initiates immediate action in the event the participation criteria are no longer met. Network providers are required to inform Humana of changes in status, including involvement in a medical malpractice suit; involuntary changes in hospital privileges, licensure or board certification; an event reportable to the NPDB; and federal, state or local sanctions, or complaints.

Delegation of credentialing/recredentialing

Note: Applicable to medical and behavioral health providers only.

Humana only enters into contracts to delegate credentialing and recredentialing if the entity that wants to be delegated is accredited by NCQA for these functions or utilizes an NCQA-accredited credentials verification organization (CVO) and successfully passes a predelegation audit demonstrating compliance with NCQA federal and state requirements. A predelegation audit must be completed prior to entering into a delegated contract. All preassessment evaluations are performed utilizing the most current NCQA and regulatory requirements. The following are included (at a minimum) in the review:

- Credentialing and recredentialing policies and procedures

- Credentialing and recredentialing committee meeting minutes from the previous year
- Credentialing and recredentialing file review

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

Effective April 1st, 2026, all providers contracted with Humana who join participating groups not delegated for credentialing receive a network effective date 30 calendar days after all required documentation is received. Claims for services rendered to members who are seen before the provider's network effective date will have claims paid at the out-of-network rate.

Credentialing and recredentialing criteria

Recredentialing

A notification will be sent to the provider for reverification of credentialing. All network providers must submit updated documents as they expire. Failure to provide updated documentation may delay payment. Your contract may be terminated at any time if it is determined the credentialing requirements are no longer being met or you fail to complete the recredentialing process.

Credentialing committee

The credentialing committee is overseen by a Humana CMO and is responsible for making determinations for all credentialing and recredentialing decisions. The credentialing committee meets monthly and is comprised of participating providers in both primary care and specialty disciplines, including behavioral health, pharmacy and midlevel practitioners. The credentialing committee has the responsibility to establish and adopt, as necessary, criteria for your participation and termination. The committee also directs credentialing procedures, including your participation, denial and termination. Failure of an applicant to adequately respond to a request for assistance may result in termination.

Credentialing decision appeals and reconsideration of decisions

Humana's credentialing committee must notify you of a denial based on credentialing criteria. The notice must inform you of the reasons for the denial and, in the case of a denial based on credentialing criteria eligible for credentialing committee reconsideration, provide notice of such opportunity to request reconsideration of the decision in writing within 30 calendar days of the notice or sooner as required by state or federal regulations. Unless otherwise noted, denial based on failure to meet administrative criteria is final with no reconsideration rights. Where applicable, in the event such reconsideration is requested in a timely manner, the credentialing committee may affirm, modify or reverse the initial decision.

Humana should notify the applicant in writing of the credentialing committee's reconsideration decision within 60 calendar days. Practitioners who were denied are eligible to reapply for network participation once they meet the minimum health plan credentialing criteria. To submit a

reconsideration request, mail the request to the senior medical director. A reconsideration request must be in writing and include all additional supporting documentation. Reconsideration requests can be sent via mail to **Credentialing Decision Appeals**.

Note: Practitioner denials due to missing DEA and/or hospital privileges have 30 business days to provide missing documentation to Humana for review as a Category I file.

After reconsideration, the credentialing committee may affirm, modify or reverse its initial decision. Humana notifies the applicant, in writing, of the credentialing committee's reconsideration decision within 60 calendar days. Reconsideration denials are final unless the decision is based on quality criteria. In these instances, you have the right to request a State Fair Hearing. Providers who were denied are eligible to reapply for network participation once they meet Humana's minimum credentialing/certification criteria.

Ongoing provider monitoring

Humana monitors provider sanctions, complaints and quality issues between credentialing cycles and ensures corrective actions are taken to address occurrences of poor quality. Ongoing monitoring and appropriate interventions including removal from the network are implemented by collecting and reviewing the following information immediately within timeline of its release:

- Medicare and Medicaid sanctions and exclusions, available online
- LEIE/OIG
- EPLS/SAM
- Sanctions or limitations on licensure
- Complaints
- Identified adverse events

Chapter 15: Fraud, waste and abuse

Contact information pertaining to fraud, waste and abuse

Contact name	Contact information	Hours of operation
Reporting FWA	SIU Hotline: 800-614-4126 Email: siureferrals@humana.com Fax: 920-339-3613 Mail: Humana Special Investigation Unit 1100 Employers Blvd. Green Bay, WI 54344	24/7 access
Ethics Help Line	Phone: 877-584-3539 Email: ethics@humana.com	24/7 access
Humana Provider Services	Phone: 800-787-3311 (TTY: 711)	Monday through Friday, 7 a.m. to 7 p.m., Central time

Overview

Fraud is defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program.

Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions but by the misuse of resources.

Abuse includes provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes beneficiary practices that result in unnecessary costs to the Medicaid program.

Both the federal government and individual states establish and monitor requirements for Medicare and Medicaid to reduce fraud, waste and abuse in the Medicare and Medicaid

programs. Healthcare fraud, waste and abuse can involve providers, pharmacists, members and even medical equipment companies. Success in combating healthcare fraud, waste and abuse is measured not only by convictions but also by effective deterrent efforts. Anyone who suspects or detects a fraud, waste and abuse violation is required to report it either to Humana or within their respective organization, which then must report it to Humana as outlined below.

You must integrate specific controls into your practice's policies and procedures to help ensure prevention and detection of potential or suspected fraud and abuse and subsequent correction of identified fraud or abuse. You must educate your employees about:

- The requirement to report suspected or detected fraud, waste or abuse
- How to make a report on the above
- The False Claims Act, which prohibits submitting false or fraudulent claims for payment and outlines the penalties for false claims and statements, whistleblower protections, and each person's responsibility to prevent and detect fraud, waste and abuse.

Humana and the state should be notified immediately if you or your office staff:

- Are aware of any provider who may be billing inappropriately (e.g., falsifying diagnosis codes and/or procedure codes or billing for services not rendered)
- Are aware of a member intentionally permitting others to use the member's ID card to obtain services or supplies from the plan or any network provider
- Are suspicious that someone is using another member's ID card
- Have evidence a member knowingly provided fraudulent information on the member's enrollment form that materially affects the member's eligibility

Information can be reported via an anonymous phone call to **Humana's Special Investigations Unit**. All information will be kept confidential. Entities are protected from retaliation⁴³ for False Claims Act complaints. Humana ensures no retaliation against callers through a zero-tolerance policy for retaliation or retribution against any person who reports suspected misconduct. You also may contact **Humana Provider Services**.

⁴³ 31 U.S.C. 3730(h)

Reporting FWA

Key features of methods for direct reporting to Humana

Anonymity: If the person making the report chooses to remain anonymous, that person is encouraged to provide enough information on the suspected violation (e.g., dates and persons, 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. 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.

Please contact the **Special Investigations Unit** or **Ethics Help Line** to report fraud, waste or abuse.

Illinois also has program integrity staff who work to guard against fraud, waste and abuse of Medicaid program benefits and resources. If you have questions or concerns regarding fraud, waste and abuse, you may contact the **program integrity department**.

Chapter 16: Pharmacy

Contact information pertaining to pharmacy

Contact name	Contact information	Hours of operation
Humana Clinical Pharmacy Review	Phone: 800-555-2546 Fax: 877-486-2621	Monday through Friday, 7 a.m. to 10 p.m., Central time
Medication Intake Team	Phone: 866-461-7273 Fax: 888-447-3430	Monday through Friday, 7 a.m. to 10 p.m., Central time
Humana Clinical Programs	Phone: 833-349-4114	

Pharmacy and therapeutics committee

The pharmacy and therapeutics committee has a responsibility to review and make decisions about the appropriate use of drugs, biologicals and select nondrug pharmacy-related products. This charge may be relevant in many contexts, including but not limited to:

- Clinical edits
- Consumer programs
- Drug utilization review
- Formulary development

Prescription drug guide

Current prescription drug guides are available online for your review.

Coverage determinations and exceptions

Please reference your integrated formulary for information on coverage determinations and exceptions. You may request coverage determinations, such as medication PA, step therapy, quantity limits and formulary exceptions through **Humana Clinical Pharmacy Review**.

The coverage determination decision will be reviewed based upon medical necessity and our decision communicated within the applicable time frames after the request is received from the prescriber.

Appealing adverse decisions regarding medication coverage

If Humana denies the member's coverage determination or formulary exception, you can ask for a review of our decision by making an appeal on behalf of the member. Please review the member grievance and appeals section of this provider manual for more details on how to submit appeals.

Peer-to-peer (P2P) discussions

If you prefer to have a discussion with one of our pharmacists or regional medical directors, you may initiate a P2P request by contacting **P2P discussions** and leave a message, including:

- Prescriber's contact information and best time to contact
- Referenced member name, date of birth and evidence of coverage information
- Prescription drug requested and reason for your call

The prescriber has 15 business days to request a P2P conversation.

Note: The P2P discussion is not considered part of the appeal process, and depending on the outcome, you may still request a formal appeal if necessary.

Dispensing limitations

Some drugs have limits on how much can be given to a member at a single time. Quantity limits may be based on several factors, such as drug manufacturers' recommended dosing, member safety, the Illinois Medicaid Drug Utilization Review Board approved limits or FDA recommendations.

UM for medications

The PDL identifies covered drugs and associated drug UM requirements, such as PA, quantity limits, age limits, etc.

- PA: The medication must be reviewed using a criteria-based approval process prior to a coverage decision.
- Step therapy: The member must utilize medications commonly considered first line before using medications considered second or third line.
- Drug safety limits: These facilitate the appropriate, approved label use of various classes of medications (e.g., drug-drug interactions, opioid limits, therapeutic duplication).
- Generic substitution: Generic drugs should be dispensed when available. If using a particular brand name is determined to be medically necessary, PA must be obtained.
- Quantity limits: Quantity limits have been implemented for various classes of drugs to facilitate the appropriate, approved label use of these agents to help members obtain the optimal dose required for treating their conditions. If a member's medical condition warrants an additional quantity, the pharmacist should ask the prescriber to submit a request to **Humana Clinical Pharmacy Review**.

- **Age limits:** Age limits have been implemented for various classes of drugs to facilitate the appropriate, approved label use of these agents to help members receive appropriate care for the member's age. If a member's medical condition warrants an exception to an age limit, the pharmacist should ask the prescriber to submit a request to HCPR.

You can review the **prescription drug guide** online.

Please review the current formulary prior to writing a prescription to determine if the drug will be covered. The PDL is updated regularly. The **current prescription drug guide can be viewed online**. To view current medical and pharmacy coverage policies, please see the Medical and Pharmacy Coverage Policies **website**.

Pharmacy copayments

Members should refer to their EOC for information on copayments.

Humana's pharmacy network

Our **online Pharmacy Directory** gives you a complete list of network pharmacies that have agreed to fill covered prescriptions for members. Providers and members can access our **Pharmacy Directory** online, and members can use our Pharmacy Finder tool by **signing in to Humana.com**.

Members have access to a mail-order pharmacy, which will send their medications directly to their home. More information about this **mail-order pharmacy option is available online**.

Continuity of care for new members

Continuity of medication coverage for newly enrolled members

We want to make the enrollment or transition into our plan as easy as possible for our members. Continuity of medication coverage helps members who have limited ability to receive their prescribed drug therapy by providing them with a temporary supply. For new members in need of drugs that require a coverage determination or formulary exception, Humana may allow a temporary supply of a drug during the first 90 calendar days of enrollment.

Medication therapy management (MTM)

Humana offers an MTM program that helps ensure members achieve the best possible outcomes from their medications. The member-centered MTM program promotes collaboration between the pharmacist, member and prescriber to optimize safe and effective medication use. The goal of this program is to optimize therapeutic outcomes by focusing on safety, effectiveness, lower-cost alternatives and adherence.

Prescribers with questions about the program may call **Humana Clinical Programs**.

Medications administered in the provider setting

Humana covers medications administered in a provider setting, such as a provider office, hospital outpatient department, clinic, dialysis center or infusion center. PA requirements exist for many injectables. Medicaid providers may contact the **Medication Intake Team** for more details. The **prior authorization list is also available online**.

Electronic prescribing

Through our participation in the Surescripts network, our pharmacy benefit manager, eligibility, formulary and member medication history is available through every major EHR or e-prescribing (eRx) vendor, including Allscripts, Epic, Oracle Cerner, athenahealth and DrFirst. Prescribers with EHRs or eRx can view real-time clinical information about the formulary, safety alert messaging and PA requirements.

Chapter 17: Long-term services and supports

Contact information pertaining to long-term services and supports

Contact name	Contact information	Hours of operation
988 Lifeline	Phone: 988 Website: 988 Lifeline website	24 hours a day, 7 days a week
Child Abuse and Neglect Hotline	Phone: 800-25ABUSE (800-252-2873) (TTY: 800-358-5117)	24 hours a day, 7 days a week
DHS OIG	Phone: 800-368-1463 Website: DHS OIG website	24 hours a day, 7 days a week
HFS SLF Complaint Hotline	Phone: 844-528-8444	Monday through Friday, 8:30 a.m. to 5 p.m., Central time
Illinois Department of Public Health (IDPH) Central Complaint Registry Hotline	Phone: 800-252-4343 Website: File a health care complaint website	Monday through Friday, 8:30 a.m. to 4:30 p.m., Central time
Illinois Department on Aging, Adult Protective Services Hotline	Phone: 866-800-1409 (TTY: 711) Website: Illinois Department on Aging Adult Protective Services website	24 hours a day, 7 days a week

Contact name	Contact information	Hours of operation
Illinois Domestic Violence Victim Services Hotline	Phone: 877-TO-END DV (877-863-6338), (TTY: 877-863-6339) Website: Domestic Violence Prevention and Intervention website	24 hours a day, 7 days a week
Illinois Helpline for Opioids and Other Substances	Phone: 833-2FINDHELP (833-234-6343) Website: Illinois Helpline website	24 hours a day, 7 days a week
LTSS Transitions	Email: HumLTSStransitions@humana.com	
National Human Trafficking Hotline	Phone: 888-373-7888 Website: National Human Trafficking Hotline website	24 hours a day, 7 days a week
Report Medicaid or Cash Program Fraud Hotline	Phone: 844-ILFRAUD (844-453-7283) Website: Illinois HFS report fraud website	

LTSS overview

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

- 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 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 because 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.

LTSS provider definition and status

The requirements for eligible providers of covered services are identified in the state 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.

LTSS 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 recertified or maintain active eligibility as the state requires. The provider contracting and credentialing policy is available through **Humana Provider Services**.

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

ADA 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.

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 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.

Care coordination and service authorization

LTSS service authorizations are created by the LTSS UM team. PA requests for PERS must be submitted through the LTSS team by either contacting the care coordinator (CC) or emailing LTSS Transitions.

The CC completes a comprehensive assessment and works with the member to identify care needs and identify resources to meet those needs. The CC creates the LTSS service plan during the visit. If care needs exceed the state-provided service cost maximums, then the service authorization request is sent to the LTSS management team for further evaluation and review for medical necessity based on member care needs. Service denials or reductions are issued from the medical director. Providers can request LTSS services, but all service PA additions or changes must go through the CC and be based on member assessment of needs. Providers can request LTSS services on the member's behalf by emailing **LTSS Transitions** or reviewing the **online prior authorization list**.

Humana Dual Fully Integrated care plans

The Humana CC 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 CC finalizes the care plan. The Humana CC and the LTSS provider may 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.

Level-of-care assessment and reassessment processes

NFLOC assessments are performed by the state's designated entity. Humana incorporates the level-of-care assessment results into the comprehensive health assessment tool (CHAT). If the member's circumstances have substantially changed since the level-of-care assessment was completed, or if more than 3 months have elapsed between completion of the level-of-care assessment and completion of the CHAT, the member's Humana CC reviews the level-of-care assessment responses with the member to confirm their accuracy.

Care and service coordinators will jointly conduct the annual CHAT reassessment for members in service coordination residing in a home- and community-based setting. The applicable CHAT results will be sent to the entity or entities designated by the state for an updated NFLOC determination as required. For members residing in nursing facilities, the results of the member's annual level-of-care reassessment conducted by the state's designated entity will be incorporated into the member's record, after which the member's CC and service coordinator will conduct a joint visit to the member to review and update the member's ICP and complete any other needed reassessments. As with the initial assessment process, the CC and service coordinator encourage the member to invite the

member's caregivers, natural supports and other chosen ICT participants in the ICT process. The CC and service coordinator ensure the updated assessments and ICP are shared with ICT participants via our CDS or another participant-preferred method of data sharing.

Needs assessment service planning requirements

Humana performs strengths-based, LTSS-specific service planning processes for these members, rooted in the principles of person-centered thinking, trauma-informed care and the 4Ms of age-friendly care (what matters, medication, mentation and mobility), and based on the results of the member's CHAT and/or level-of-care assessment.

As with our CHAT completion process, we will encourage members completing LTSS-specific assessments to include their informal caregivers, family members and other individuals in the member's circle of support in the assessment conversations.

To reduce member abrasion and support a cohesive and streamlined assessment process, the service coordinator will complete the LTSS-specific assessments during the same visit as the CHAT. This dual visit, with both the CC and service coordinator participating, also ensures that both the CC and service coordinator get the full picture of the member's needs, preferences and goals across all service types.

The service coordinator uses the information gathered via the LTSS assessments to develop the member's service plan, working in collaboration with the member and the member's supports and ICT to identify those services and supports that best meet the member's needs and goals, including a goal to transition to a less restrictive setting. As with the CHAT, we design our CDS platform to directly link the LTSS assessments with the service plan. The service coordinator will be prompted to add a service or intervention for each identified need, ensuring that all member needs are addressed with a service that fits the member's preferences and desires.

Member transition to another LTSS network provider

Humana helps members transition to a new provider if their former provider leaves Humana's network during and after the transition period.

HCBS waiver service	Elderly (DOA)	Disability (DHS)	HIV/AIDS (DHS)	Brain injury (DHS)	Supportive living (HFS)
Adult day service	X	X	X	X	
Adult day service transportation	X	X	X	X	
Assisted living ⁴⁴					X
Automated medication dispenser	X				
Behavioral services (MA and PhD)				X	
Environmental accessibility adaptations—home		X	X	X	
Habilitation—day				X	
Home delivered meals		X	X	X	
Home health aide		X	X	X	
Homemaker	X	X	X	x	
Individual provider, including personal assistant ⁴⁵		X	X	X	
Nursing—skilled (RN and LPN)		X	X	X	
Nursing, intermittent		X	X	X	
OT		X	X	X	
PERS	X	X	X	X	
PT		X	X	X	
Prevocational services				X	
Respite		X	X	X	
Specialized medical equipment and supplies		X	X	X	
ST		X	X	X	
Supported employment				X	

⁴⁴ Nursing services, personal care, medication management, including administration, social and recreational programming, health promotion and exercise programs, 24-hour response/security, emergency call system, daily checks, laundry, housekeeping, maintenance, ancillary services

⁴⁵ Contingent on compliance with collective bargaining agreement and accompanying side letter between Service Employees International Union and the state

HCBS

During service planning, service coordinators leverage their experience, training and expertise to evaluate individual member needs and recommend appropriate services and supports. Service coordinators enter authorizations into our CDS platform during the CHAT and LTSS-specific assessment process and the creation of the member's person-centered service plan. The member's service plan serves as the authorization for LTSS and HCBS services. Humana's CDS platform eases member and provider burden by automatically reviewing requested services against our clinical review criteria (as approved by the state) in real time and auto-approving services that meet our predetermined thresholds.

Procedure

1. Humana uses our CDS platform to create automated authorization for LTSS.
2. Humana has built into our CDS system logic that recommends services based on individual assessment results. Each recommendation is presented with a total number of hours according to service type and the decision-making guidelines or tools approved by the state.
3. Recommended services can be approved by the service coordinator in real time if the member agrees. All member requests that differ from the recommendation are sent to our UM team for review.
4. Our UM program is evidence based and guided by a set of clinical practice guidelines adopted from clinically sound and reputable agencies.
5. All decisions to deny a service authorization request for a service in an amount, duration or scope that is less than requested are made by a medical director.
6. All member-initiated decisions to authorize a service authorization request for a service in an amount, duration or scope that is less than recommended are auto-approved and indicated that the member declined the additional services.
7. Once the service plan is created and authorization requests are approved, service authorizations are automatically delivered to the provider.
8. Humana aligns authorization requests with the services documented and agreed upon by the member/representative on the member's plan of care. The authorized services will be ongoing according to the time frames specified in the agreed-upon service plan.
9. The service request/authorization sent to the provider contains an authorization number and an effective date. Service authorization requests that include service type, frequency and duration as specified in the service plan are sent to contracted and noncontracted providers within 24 hours of the initial face-to-face visit.
10. The service plan provided to the member includes a listing of the services and items that will be authorized by Humana, detailing the name of each service or item to be furnished; the frequency and duration of each service, including the start and stop date; for LTSS, the units authorized; and for each service, the provider's name.

11. Humana typically authorizes HCBS services for a duration of 12 months, which will update when the member's condition changes.
12. Continuing authorization of services occurs via the process described above.
13. Humana does not delay service authorization if written documentation is not available in a timely manner. Covered services are not denied based on an incomplete service plan. However, Humana is not required to approve claims for which written authorization is not available.
14. Humana measures compliance with standards for processing authorization requests in a timely manner.

HCBS 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 SLFs, 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 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.

Service plan timeline requirements

We will adhere to the following timeline requirements for completion of the service plan.

Service coordinators conduct an initial face-to-face visit and include any LTSS assessments within 90 calendar days of implementation when the member has already been determined to meet NFLOC and is receiving HCBS.

At enrollment, when a member is determined to meet NFLOC and already receiving HCBS prior to implementation, the member's service coordinator will conduct an initial face-to-face visit, administering any LTSS assessments and updating the member's service plan with any modifications to the HCBS needs.

Service coordinators will conduct a face-to-face visit with NFLOC members receiving short-term nursing facility care on the effective date with Humana prior to the expiration date of the approved nursing services but no more than 90 calendar days after implementation.

If there is an increase in the member's needs before the initial CHAT or LTSS assessment can occur and the member is already determined to meet NFLOC and receiving HCBS/short-term nursing facility care, the service coordinator will immediately conduct a functional needs assessment. The service plan also will be updated accordingly.

The service coordinator will conduct a face-to-face, in-facility visit within 90 calendar days of implementation and conduct a needs assessment when the member resides in a nursing facility for fewer than 90 calendar days at enrollment.

The service coordinator will conduct quarterly face-to-face visits every 90 calendar days at the facility to assess the member's needs and/or transition the member.

For members who are determined to meet NFLOC by the state-designated entities following a referral by or on behalf of a member, regardless of referral source, the service coordinator will conduct a face-to-face visit with the member and complete and approve a service plan within 5 business days of receiving the member's NFLOC determination notification from the state-designated entity.

Providers should begin services as soon as possible and within 20 business days of receiving a notification from the service coordinator, as indicated on the service plan. The service coordinator will verify all HCBS included in the member's service plan, except home modification and vehicle modification, are started or delivered within 30 calendar days of the initial service plan.

For requests related to HCBS, once a decision to deny has been made, a notice to the member will be provided within 24 hours.

Our CCs and service coordinators ensure that the requisite level of support is provided for ensuring the member directs the person-centered planning and ICT process to the maximum extent possible and is empowered to make informed choices and decisions.

Our person-centered service planning process will include, but is not limited to, the following requirements:

- Identifying, coordinating and supporting members in gaining access to LTSS services and other covered services
- Identifying, coordinating and assisting members in gaining access to noncovered medical, social, housing, educational, financial and other services and supports, including services provided by other community resources
- Informing members about available LTSS, required assessments, the person-centered service plan, service alternatives and service delivery options, including participant direction, risks and responsibilities
- Protecting a member's health, welfare and safety, including developing an emergency plan
- Facilitating member access to locating, coordinating and monitoring needed services and supports
- Collecting additional necessary information, including, at a minimum, member preferences, strengths and goals
- Reassessing a member's level of care annually
- Assisting in identifying and choosing willing and qualified providers
- Coordinating efforts and prompting the member to complete activities necessary to maintain LTSS eligibility
- Exploring coverage of services to address member-identified needs through Medicaid and other services such as Medicare, private insurance, Veterans Affairs services and other informal unpaid supports
- Actively coordinating with other individuals and entities essential in the physical and social care delivered for the member to provide for seamless coordination
- Referring to all training, education and resources for informal caregivers as required in the Informal Caregiver Supports and Informal Caregiver Coaching section of the contract

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 PA 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](#).

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 the member's 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 health plan benefit. The team develops an 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 or 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.

Providers must comply with all applicable federal and state laws⁴⁶ and all laws regarding privacy and confidentiality.

Helpful resources for critical incidents and adverse events

- For children younger than 18, call the national **Child Abuse and Neglect Hotline**.
 - For more information, please refer to the **Illinois Department of Child and Family Services website**.
- For members age 18 and older with disabilities and seniors living in the community, or if the abuse, neglect or exploitation occurs in the community to a member living in a licensed facility, contact the **Illinois Department on Aging, Adult Protective Services**.
- For more information, please refer to the **Illinois APS website**.
- For members in nursing facilities, please contact the **Illinois Department of Public Health (IDPH) nursing home complaint** hotline or refer to the **IDPH complaint website**.
- For members age 18 to 59 receiving mental health or developmental disability services in DHS- operated, licensed, certified or funded programs, please contact the **DHS OIG** or visit the **DHS website**.
- For members in SLFs, contact the **HFS SLF complaint hotline**.
- You can also contact the **Illinois Domestic Violence Victim Services hotline** or visit the **domestic violence prevention and intervention website**.
- To report SNAP, Link, Medicaid, cash and retail fraud, contact the **Report Medicaid or Cash Program Fraud hotline**, call 844-ILFRAUD (844-453-7283), or visit the **Illinois HFS report fraud website**.

⁴⁶ Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. Part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFH Part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act

- Members struggling with opioid and other substance use can contact the **Illinois Helpline** or visit the **Illinois Helpline website**.
- Members in crisis can reach the **988 Suicide and Crisis Lifeline** or visit the **988 Lifeline website** for more information.
- Human trafficking can be reported to the **National Human Trafficking Hotline**, and more information is available on the **National Human Trafficking hotline website**.

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 publishes additional training and education about claims submission within the **provider orientation** and on the **Illinois provider training materials website**.

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.⁴⁷ 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.

⁴⁷ 45 C.F.R. § 160.103

Appendices

Definitions

Term	Definition
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 C.F.R. 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 Humana Dual Fully Integrated plan regarding the provision of MCO health services
County health departments (CHD)	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 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

Term	Definition
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 person or fetus • Serious impairment to bodily functions • Serious dysfunction of any bodily organ or part With respect to pregnant people: • 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 C.F.R. 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 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 (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

Term	Definition
Health plan	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 5/3 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 • Humana Dual Fully Integrated 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	Humana Dual Fully Integrated 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 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.

Term	Definition
Medicare	the medical assistance program authorized by Title XVIII of the Social Security Act
Member	a 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 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
prior authorization	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

Term	Definition
Provider	a person or entity that meets all state and/or federal requirements (as appropriate) to provide covered services to 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 (quality improvement)	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.

