

Provider manual

For physicians, hospitals
and healthcare providers



Humana®

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I. Overview

About Humana: Humana Inc., headquartered in Louisville, Kentucky, is one of the nation's largest publicly traded full service health, well-being solutions and supplemental benefits companies. Humana Inc.'s affiliated health plans ("Humana") offer a wide array of health insurance and well-being products and related services through traditional and consumer-choice health plans ("Plans") to employer groups, government-sponsored Plans, and individuals, as well as primary and workplace care through its medical centers and worksite medical facilities. Over its more than 50 year history, Humana has consistently seized opportunities to meet changing customer needs. Today, the company is a leader in consumer engagement and providing guidance designed to lead to a better Plan experience throughout its diversified customer portfolio.

ChoiceCare® Network: The ChoiceCare Network is Humana Inc.'s national PPO rental network and includes over 500,000 Providers and 2,700 hospitals across all 50 states and the District of Columbia. Provider Participation agreements are written with physicians, hospitals, and health care providers for all states. The ChoiceCare Network serves small and large group PPO and self-insured employers, insurance companies, governmental agencies, third party administrators, and other similar entities as customers. Refer to Chapter Two of this Manual for additional information regarding the ChoiceCare Network.

Health Value Management Inc., d/b/a ChoiceCare Network ("ChoiceCare"), is a wholly owned subsidiary of Humana Inc. **Note:** Humana contracts with numerous other providers for participation in Humana's provider networks that are not part of the ChoiceCare Network.

Purpose of this Manual: Humana's Provider Manual for Physicians, Hospitals and Other Health Care Providers ("Manual") is an extension of the provider participation agreement ("Agreement") between Humana and/or ChoiceCare and all provider types including, but not limited to, physicians, hospitals and ancillary health care providers (hereinafter collectively and/or individually, as the context requires, referred to as "Provider(s)"). This Manual furnishes all such participating Providers and their office staff with important information concerning Humana and ChoiceCare policies and procedures, claims submission and adjudication requirements, and guidelines used to administer Humana health Plans. This Manual replaces and supersedes any and all other previous versions and is available on Humana.com, Availity.com and ChoiceCare.com. A paper copy may be obtained at any time upon written request to Humana. Any capitalized terms not otherwise defined herein shall have the meaning as set forth in the Agreement.

In accordance with the **Policies and Procedures** clause of the Agreement, Providers are contractually required to abide by all provisions contained in this Manual, as applicable. Revisions to this Manual constitute revisions to Humana's policies and procedures. Revisions shall become binding ninety (90) days after the date indicated on any notice that is provided by mail or electronic means, or such other period of time as necessary for Humana to comply with any statutory, regulatory and/or accreditation requirements.

As policies and procedures change, updates will be issued in the form of National Provider Bulletins and may be incorporated into the electronic version and subsequent paper versions of this Manual. Any change in policies and procedures must be implemented according to the time frame included in the Agreement. Provider Bulletins that are state specific may override the policies and procedures in this Manual.

Variations in applicable laws, regulations and governmental agency guidance, including, but not limited to state or federal laws, regulations, and/or changes to such laws, regulations or guidance may create certain requirements related to the content in this Manual that are not expressly set forth in this Manual. Any requirements under applicable law, regulation or guidance that are not expressly set forth in the content of this Manual shall be 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. Providers are responsible for complying with all laws and regulations that are

applicable. **Note, however, that state law and/or regulations do not affect the adjudication of claims for Medicare Advantage Members.**

Responsibility for Provision of Medical Services: Providers are independent contractors and are solely responsible to Members for the provision of health services and the quality of those services. This means Providers and Humana do not have an employer-employee, principal-agent, partnership, joint venture, or similar arrangement. It also means that Providers have a duty to exercise independent medical judgment to make independent health care treatment decisions regardless of whether a health service is determined to be a Covered Service. Nothing in the Agreement or this Manual is intended to create any right for Humana to intervene in the Participating Provider's medical decision-making regarding a Member. Additionally, Providers are responsible for the costs, damages, claims, and liabilities that arise out of their own actions. Humana does not endorse or control the clinical judgment or treatment recommendations made by Providers.

Humana requires preauthorization with respect to certain services and procedures. Humana's preauthorization determination relates solely to administering its Plans and is not, nor should it be construed to be, a medical decision. Provider, along with the Member, make the decision whether the services or procedures are provided.

Medical Directors: Medical directors serve as the major interface between health care organizations and participating Providers and other health care Providers in the community. The medical director is not engaged in the practice of medicine while acting in the medical director role. The role is invaluable in establishing a Provider network as well as facilitating Provider participation and cooperation. The medical director's responsibilities include, but are not limited to, the oversight of:

- Quality Management Programs required by federal or state law or accrediting agencies
- HumanaHealth Programs
- Credentialing
- Utilization Management ("UM")/Health Services

Humana Plans: Humana offers a variety of health Plans through its insurance subsidiaries; however, not all Plans are available in all markets. Contact the Provider representative in the local Humana market office for specific information or call provider relations at 1-800-626-2741.

QUESTIONS OR COMMENTS: Questions or comments about this Manual should be directed to the Provider representative in the local Humana market office. Any suggestions regarding this Manual or its contents should be directed to:

Humana
National Network Operations - HUM 07
500 W. Main Street
Louisville, KY 40202

II. Contact Information

Address Change or Other Practice Information

In order for Humana to maintain accurate participating Provider directories and also for reimbursement purposes, Providers **are contractually required** to report all changes of address or other practice information electronically via Humana.com or in writing as soon as possible to the local Humana market office. Notices of any changes must adhere to time frames outlined in the Agreement.

If Provider's Agreement with Humana is through Management Services Organizations (MSO), Independent Practice Associations (IPA), or provider medical groups, these changes must be communicated to Humana through the entity rather than by the Provider.

Changes that require notice to Humana may include, but are not limited to, the following:

- Provider information
- Tax identification number*
- National Provider Indicator (NPI)
- Address
- Phone number
- Practice name
- Adding a Provider – Provider joining practice/group**
- Provider deletions – Provider no longer participating with the practice/group
- Medicare numbers

*Changes in practice name, legal entity or tax ID numbers may require an amendment, assignment or new Agreement depending on the reason for the change. Check with the Provider representative in the local Humana office for specific information.

**If adding a Provider, the new Provider must first be credentialed before rendering treatment to any Plan Member.

Humana requires that changes such as those outlined above be submitted at least thirty (30) days prior to the effective date of the change to facilitate accurate directory information and claims payment.

Contact Us

Member Eligibility Inquiries:

- Visit: Humana.com, Availity.com; or
- Telephone: Commercial Members call: 1-800-4HUMANA (1-800-448-6262), or Medicare Advantage/Medicaid Members call: 1-800-457-4708

Note: A copy of the Medicare enrollment form may serve as verification of eligibility for Medicare Members who have not received their Member ID card at the time of service. Members may not be denied medical services.

Humana's verification does not guarantee payment. If Humana subsequently learns that the Member was ineligible on the date of verification, no payment will be made. Therefore, it is important that Providers always ask a patient for his or her most recent insurance status.

Preauthorization and Notification:

Access the Humana.com secure Provider Portal, Availity.com or call 1-800-523-0023

Provider Relations:

Telephone Number: 1-800-626-2741; Fax Number: 1-800-626-1686; 8 a.m. to 5 p.m. CST.

Provider Representatives:

In most Humana markets, Provider representatives serve as liaisons between participating Providers and Humana. Questions regarding HMO membership moves and issues related to Agreements should be directed to a Provider representative in the local Humana market office or by calling provider relations at 1-800-626-2741.

Humana Customer Service:

Call 1-800-4HUMANA (1-800-448-6262) or call the number listed on the back of the Member's ID card. Contact Humana customer service for assistance with questions regarding:

- Benefits
- Claims
- Copayments
- Eligibility
- Grievances and/or appeals
- Provider directory concerns

Concurrent Review:

Initial admission: 1-800-523-0023

Referrals:

Telephone: 1-800-523-0023. Referrals may also be submitted electronically via Humana.com. (Contact the Provider Deployment Team for information on electronic submissions or call Humana Customer Service (1-800-4HUMANA) for the name of the Humana connectivity consultant for a specific area).

Provider Deployment Team:

Send an email (deployment@humana.com) or call the e-Business toll-free number: 1-877-260-7360 to reach the consultant for your area. The Provider Deployment Team can provide information on electronic tools and resources and assist with the setup process for electronic submission of claims.

Real Time Claims Adjudication:

Contact the Provider Deployment Team for information.

HumanaAccess Card:

1-800-604-6228 (Humana's Spending Account Administration team)

HumanaFirst®:

1-800-622-9529 – Humana provides a nurse advice and health information telephone line for Members to call 24 hours a day, 7 days a week. The HumanaFirst program also has a library of Member education tapes that the caller can access.

Preventive Health Services:

An important aspect of health care is the delivery of preventive health services. Due to the variety of health care services available to Members, contact Humana Customer Service for assistance. Member levels of benefit coverage may vary for these services.

Transplant Management:

Contact the Transplant Management team at 1-866-421-5663 as soon as the transplant service is being considered.

Bariatric Management:

Contact the Bariatric Management team at 1-866-486-5295 for bariatric services.

Neonatal Intensive Care Unit (NICU):

Contact the NICU team at 1-855-391-8655 for Neonatal Intensive Care services.

Case Management:

Contact the Case Management team for referrals into case management as follows: Medicare/Medicaid: 1-800-322-2758; Commercial: 1-800-327-9496

Fraud, Waste and Abuse:

Humana Hotline: 1-800-614-4126.

Humana.com/Availity.com

Network Providers may log onto Humana.com and/or Availity.com (in select markets) for administrative and informational needs pertaining to Humana. The unsecured section of Humana's site offers a variety of information resources, including Humana's drug list and links to clinical practice guidelines. The secured section of the site features transactional capabilities, such as Member eligibility verification, claims status, authorization inquiry, referral submissions, and fee schedule information.

Humana.com Unsecure Provider Section (no registration is required):

- **Clinical and Health Care Resources:** Quickly locate details about Humana’s clinical practice guidelines, patient health education, clinical services and innovation, transplant services, bariatric services and disease management programs.
- **Continuing Medical Education (CME) Opportunities:** Find online opportunities to learn the latest information and recommendations regarding health care best practices.
- **Provider Medicare Information:** Provides more information about Plans offered in specific areas.
- **Preauthorization and Notification List:** Provides a comprehensive list of services and medications outlining which services and Plans require preauthorization and notification only.
- **Provider Appeal Process:** Provides an explanation of the appeals process for medical doctors and doctors of osteopathy.
- **Credentialing Services:** Council for Affordable Quality Healthcare (CAQH) – Provides a link to CAQH’s Universal Credentialing Datasource.
- **Provider Web-based Tutorials:** Get the most out of Humana’s Web tools by attending a Provider Webinar session.
- **Resources for Humana-insured patients:** Learn more about services that may benefit patients with Humana Plans.
- **Prescription Tools and Resources:** Learn more about Humana’s pharmacy programs by using the drug list search, prescription tools and resources and pharmacy locator.
- **Claims edit and policy information**

Humana.com Secure Provider Section (registration required):

Humana’s secure, Self-Service Center offers online tools to help health care professionals, including third-party administrators and streamline administrative tasks. Humana has also developed security programs to address legitimate concerns about access to sensitive medical data. This allows Members to block information they want to remain confidential. To enter the secure Provider Self-Service area, Providers must register on Humana.com. The tools on Humana.com are available 24 hours a day, seven days a week. Similar features are available on Availity.com. After registration has been completed, the following may be accessed:

- | | |
|---|--|
| • Eligibility and benefits inquiry
(includes out-of-pocket accumulators) | • Online electronic claims submission
(via ZirMed®) |
| • Certificate of coverage access | • Electronic funds transfer registration |
| • Referral/authorization submission,
modification and inquiry | • Service Fund view and download |
| • View and submit outpatient service
authorization | • Provider directories |
| • Claims status inquiry | • Referral summary report |
| • Remittance advice inquiry and download | • Code-editing information |
| • Fee schedule inquiry | • Humana’s Rules of Participation for Medicare
Advantage Networks |

III. Claims Procedures

Checking Member Eligibility

To Check Eligibility via the Web: If Provider is registered in the secured Provider self-service area on Humana.com or Availity.com, a specific Member’s eligibility can be checked online by entering the subscriber’s identification (ID) number.

If Provider is not yet registered on Humana.com: Go to the “Providers” link, then select “Register for Self-Service” and follow the instructions. Registering online allows Providers to check patient eligibility information, submit Humana professional claims, check claim status and much more 24 hours a day, seven days a week. Please note that registration requires two check numbers for validation. Check numbers can be found on Humana payments.

If a Provider is not yet registered on Availity.com, go to www.availity.com and select “Register Now.” Follow the prompts to complete the online registration process.

To Check Eligibility via the Phone:

- Call Humana Customer Service at 1-800-4HUMANA or the number listed on the back of the Member’s ID card.
- Provide the subscriber’s identification number and other authentication information

Member Identification (ID) Card


The Member identification (ID) card is issued to Members upon enrollment and contains information regarding benefit coverage, copayments, and telephone numbers for questions regarding those benefits. Members’ Social Security numbers have been replaced with unique Member identification (UMID) numbers that are assigned by Humana. For some Plans, the UMID is comprised of one alpha character and eight digits followed by a two-digit dependent code, such as H12345678-02. Other Plans will have a nine-digit all numeric ID number. The reason for the change is to protect a Member’s privacy in accordance with HIPAA regulations. Key information is identified on the sample identification card below.

HUMANA.

MEMBER ID
9999999999

MEMBER NAME
Last Name
First Name

MEDICAL COVERAGE



COPAYMENT

PPO

GROUP NUMBER
77777777

EFFECTIVE DATE
MM/DD/YY

PPO NETWORK
OFFICE COPAYMENT
\$xx.xx

EMERGENCY ROOM
\$xx.xx

Present this card to your provider at the time services are rendered.
Precertification is required, please call 1-xxx-xxx-xxxx
For more information, refer to your Certificate of Coverage
Benefit and Claims Information: 1-xxx-xxx-xxxx
Enrollment Changes: Contact your local HR representative
Provider Verification: to verify if your doctor, hospital, or facility
is in the ChoiceCare Network: Call 1-xxx-xxx-xxxx

This plan provides automatic assignment of benefits to the provider. Mail itemized bills, including diagnosis to the Plan Supervisor at:

Attn: Claims Department
Payor's Name
Payor's Claims Department Address
Payor's Claims Department City, State, Zip Code
Payor's Offering Statement

Note: In order to avoid potential problems with identity theft or fraud, ask the Member for a separate form of identification along with the Member ID card, such as his/her driver’s license.

When applicable, a copayment is collected from the Member at the time of service. Copayments for office visits and prescriptions are listed on the Member’s ID card. Since copayments are subject to change, it is recommended that copayment amounts be verified via Humana.com and/or Availity.com, or by calling the number listed on the back of the Member’s ID card.

Providers should have a timely process in place to refund Members any difference between their copayment and the allowable amount for the office visit (in instances when the allowed amount is less than the copay collected) when the claim is processed by Humana. For assistance with questions, please contact Humana Customer Service at the number listed on the back of the Member’s ID card.

HumanaAccessSM Visa[®] Cards

HumanaAccess cards are issued to Members with Health Savings Accounts (HSA), Personal Care Accounts (PCA) or Flexible Spending Accounts (FSA). Two types of HumanaAccess cards may be used at physician offices, medical labs, hospitals and for other eligible medical expenses. Both types are defined below.

- 1) **Combined ID and Visa card:** Some Humana Members will have a HumanaAccess card, which will be used as their identification card and as a debit (credit) card for payment of specific medical expenses. Below is a sample of the combined ID and Visa HumanaAccess card:



- 2) **Stand-alone HumanaAccess card for Members with Humana FSA Plans:** This is not a medical ID card. This card enables the Member to access FSA funds only. Some Members may have separate medical insurance ID cards as well as this card.

Below is a sample of the stand-alone HumanaAccess card:



Please note the following:

- Humana Members may carry both types of HumanaAccess cards.
- Some Members who carry the stand-alone Visa card may not have Humana medical coverage.
- The Humana Member must activate the HumanaAccess card prior to use.
- If it is necessary to make a copy of the HumanaAccess card, mark out the Visa account number on the copy to prevent fraud.
- The Member must have funds available to cover charges to the card.
- The card will be declined if there are insufficient funds.
- Only the subscriber's name appears on the HumanaAccess card.

To Process payments for qualified medical expenses with the HumanaAccess Card:

The Member may present the HumanaAccess card at the time of service or use it as a form of payment after he/she receives the bill. If there is no copayment, as with a Humana Plan with a PCA, "N/A" will be reflected under the copayment line. To process the card for a payment:

- Swipe the Member's card through the Visa card machine.
- Even though the card is a debit card, select "credit," if prompted. (No personal identification number (PIN) is required.) The payment is automatically deducted from the Member's appropriate HSA, PCA or FSA.
- Provide a receipt to the Member and payment will be received with other Visa payments

Deductibles and Coinsurance:

In order to obtain payment directly from the Member's account for deductibles and coinsurance, consider using a "Patient Easy Pay Consent" form, which is available on Humana.com, Provider section, or may be obtained from the local Humana market office or by calling provider relations at 1-800-626-2741.

Two Distinct Ways to Use the HumanaAccess Card:

There are two ways the card should be charged for medical expenses. Humana is aware that some offices, as policy, charge a portion of the service at the time of the visit in place of a copayment, when a copayment does not apply to the service. The best and most appropriate use of the HumanaAccess card for medical expenses is defined below:

1. **Copayments at time of visit:** Swipe the card upfront at the time of visit for copayments only. (**Note:** Some Plans do not have a copayment.) Press the credit key even though it is a debit card.
2. **Coinsurance and Deductibles after the office visit:** When the remittance process provides the Member-owed portion of the claim, key in the number and expiration date. The Member's card will automatically be charged. (**Note:** Provider will need to have an Easy Pay Consent Form (available on Humana.com in the Providers section) on file, signed by the Member, allowing the provider to charge Member's payment card for the balance of fees not paid by insurance company.

Humana recommends waiting until the claims adjudication process is complete before portions of the deductible or coinsurance are charged to the card. This is a more hassle-free approach, enabling the correct amount to be charged to the card and eliminating back-end reconciliation issues.

If Provider's internal office policy requires a form of upfront payment, charge a small percentage of the expected cost to the card. For fee schedule guidance, Member deductibles and coinsurance, go to the secure area of Humana.com. If the amount charged on the card does not match the adjudicated claim amount, the Member will need the receipt to reconcile the final charges. The IRS has very stringent reconciliation guidelines and auditing processes for funding accounts like FSA and PCA accounts. In addition, the office will need to issue a timely credit (or debit) to the card for any difference between the charged amount and the actual Member responsibility.

Member Overpayments and Credits to HumanaAccess Cards:

There are a variety of situations which may cause a Member's HumanaAccess card to be overcharged. When this happens, please credit the Member's HumanaAccess card account promptly, as the Member's funds may be needed for other medical expenses. Be advised that these funds belong to the Member – not Humana. If a Humana Member has overpaid with the HumanaAccess card and is due a credit:

- Do not issue a check.
- Credit the amount owed to the Humana Member directly back onto the HumanaAccess card by running a credit transaction through Provider's Visa terminal.
- Notify the Member of any transaction.

To avoid overcharging situations, Humana recommends waiting until the claims adjudication process is complete before portions of the deductible or coinsurance are charged to the card. For assistance with problems in processing a Member's payment with the HumanaAccess card, call Humana's Spending Account Administration Team at 1-800-604-6228.

Preauthorization and Notification (Utilization Management)

Preauthorization is required or notification is requested for certain medications and medical services under most Humana Plans. For Providers to determine whether preauthorization or notification is required for a Humana Member, Providers should review the Humana preauthorization and notification

list (on the Provider section of Humana.com) or call Customer Service (1-800-4HUMANA) to obtain a copy of the preauthorization and notification list.

Humana's preauthorization and notification list is subject to change. New-to-market drugs may be added monthly to the list of medications which require review. Humana also reviews and may update the preauthorization and notification list at least biannually. Changes to the preauthorization list outside of the new-to-market drugs are communicated through notices to Providers in accordance with Agreements.

To initiate a preauthorization or notification, a Provider may visit Humana.com, Availity.com or call the number for precertification on the back of the Member's ID card. For urgent authorizations or notifications, call clinical intake at 1-800-523-0023. Staff is available from 7:00 a.m. to 6:00 p.m. CST, Monday through Friday, to discuss preauthorization issues.

The following information is required for a preauthorization or notification request:

- Subscriber's name
- Member's ID number, name and date of birth
- Date of actual service or hospital admission
- Date of proposed procedure, if applicable
- Procedures codes
- Bed type: inpatient or outpatient
- Tax ID number of treatment facility (where service is being rendered)
- Tax ID number of servicing provider (provider performing service)
- Applicable ICD diagnosis code
- Caller's telephone number
- Attending physician's telephone number

Note: Authorization/Notification is not a guarantee of payment. Billed services are subject to the review for medical necessity, appropriate setting, billing and coding, plan limits and eligibility at the time of service.

For Medicare Advantage Plans:

Advanced Beneficiary Notices (ABNs)

As a Medicare Advantage Organization (MAO), Humana may not use the Advanced Beneficiary Notice (ABN) document created by CMS. However, MA Members must be notified in advance when a Provider believes there is a substantial likelihood that a specific service will not be covered. This notice may be either verbal or in writing; the Provider is encouraged to document the discussion and bill using the appropriate modifier.

National Coverage Determinations (NCDs) and Local Coverage Decisions (LCDs)

Humana applies National Coverage Decisions and Local Coverage Determinations according to criteria set forth within.

Advanced Coverage Determinations (ACDs)

For procedures or services that are investigational, experimental or may have limited benefit coverage, or for any questions about whether Humana will pay for a service, the Provider may request an Advanced Coverage Determination on behalf of the Member prior to providing the service. Members may be contacted if additional information is needed. ACDs for Members may be initiated by submitting a written request to:

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

Retrospective Review: Retrospective review consists of a clinical review. A written summary of medical necessity and services provided must be submitted by the provider stating why proper authorization was not obtained.

Clinical Review Criteria Guidelines: The clinical review criteria guidelines are available on Humana.com (Provider section > Medical Coverage Policies) or a copy of the specific Utilization Management criteria may be obtained from the local market office upon request.

Concurrent Review: Concurrent review is the process that determines coverage during the inpatient stay (including, but not limited to, Skilled Nursing Facility (“SNF”), Long Term Acute Care Hospital (“LTAC”) and Inpatient Rehabilitation facility). Contact Humana when a Member has been admitted by calling 1-800-523-0023. Provide the facility tax ID number, Member name, Humana Member ID number or Social Security number, date of birth, admit date and diagnosis. Each admission will be reviewed for medical necessity and compliance with contractual requirements. Humana will contact the Provider if additional clinical review is required. In addition to the information provided for the initial admission, indicate complicating factors that prevent discharge by calling the number listed on the back of the Member’s ID card. Providers must contact Humana once a discharge date has been determined advising of the discharge date and discharge disposition.

Note: Humana follows CMS regulations regarding the Inpatient-only Procedures list for MA Plans. Additional information can be found on **Humana.com**, Providers section.

Referrals

In Plans where referrals are required, the primary care physician (“PCP”) will receive a referral number from Humana if the referral request is: 1) completed and Humana determines the services are covered under the Agreement; 2) provided by an approved Provider/facility; and 3) medically necessary. An approved referral number does not override Member eligibility, participation Agreement exclusions, etc. Prior to rendering services, preauthorization must also be obtained by the specialist for any additional medications or medical services on the preauthorization and notification list which are to be provided by the specialist.

The status of a referral can be verified by accessing Humana.com, Availity.com or by telephone (1-800-523-0023). After the Member has been treated, the specialist’s findings, diagnosis, and recommendation for treatment should be sent in writing to the Member’s PCP. The specialist must also submit claim/encounter data to Humana.

Note: Original Medicare does not cover some services or supplies when they are ordered/referred unless certain requirements (e.g., qualifications of the ordering/referring Provider and billing requirements) are satisfied. For Medicare Advantage Members, Humana follows Original Medicare billing and enrollment requirements for services and supplies covered under Original Medicare.

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

- Surgical procedures
- Treatment for a serious injury or illness
- Other situations in which the Member feels that he/she is not responding to the current treatment plan in a satisfactory manner

HMO Members may obtain a second opinion by a physician of his/her choice, but the PCP must issue a referral. The final treatment plan is determined by the Member’s PCP. Follow-up services must be obtained through or arranged by the Member’s PCP.

Peer-to-Peer Review: Prior to or at the time an adverse determination is communicated, the Provider ordering services is given an opportunity to discuss the plan of treatment for the Member and the clinical basis for treatment with a health Plan medical director. **Note:** Contact Humana Customer Service (1-800-4HUMANA) with any questions.

Inpatient Coordination of Care: In the event coverage guidelines for an inpatient stay are not met and/or the Member's certificate does not provide the benefit, a licensed, medical professional will consult with the PCP and/or attending physician. If necessary, the licensed, medical professional will refer the case to a health Plan medical director for review and possible consultation with the attending physician. If the health Plan medical director determines that coverage guidelines for continued hospitalization are no longer validated, the Member, attending physician, hospital, and the Member's primary care office will be notified in writing that benefits will not be payable if the Member remains in the hospital on and after the effective date of the nonapproval.

Skilled Nursing Facility: The PCP may contact Humana Customer Service to obtain authorization for a SNF admission at the time the Member is being admitted to the skilled nursing facility. If a request for an admission to a SNF is in question, the case is referred to a health Plan medical director for review. The Provider is given a reasonable opportunity to discuss the plan of treatment for the Member and the clinical information for the admission with the health Plan medical director prior to issuance of an adverse payment determination. The Provider may appeal an adverse payment determination (please see the Provider Claims Reconsideration section of this Manual for more information).

PPO Plans: Under a PPO Plan, referral is not required from a PCP for specialist visits. Preauthorization for medications and medical services on the preauthorization and notification list is required. The preauthorization requirements are posted on Humana's Provider website or a copy may be requested from Humana Customer Service (1-800-4HUMANA).

HMO Plans: If a Member requires specialized treatment beyond the scope of the PCP, the Member is referred to a specialist for consultation and/or treatment. Humana contracts with specialists in the Plan's service area. Specialties may include, but are not limited to:

- | | | |
|---------------------|----------------------|--------------|
| • Allergy | • Gastroenterology | • Oncology |
| • Bariatric Surgery | • General Surgery | • Pathology |
| • Anesthesiology | • Hospitalists | • Psychiatry |
| • Cardiology | • Infectious Disease | • (MBHO) |
| • Dermatology | • Mental Health | • Podiatry |
| • Emergency Room | • Neurology | • Pulmonary |
| | • Obstetrics | • Transplant |

For Plans that require referrals, the PCP initiates the referral by submitting a referral request to Humana via Humana.com, Availity.com, telephone or facsimile using the Humana Referral Request form.

Medical Coverage Policies

Humana's medical coverage policies are available on Humana.com, Providers' section. These policies describe the evaluation and coverage of medical procedures and devices that are being investigated or have been recently introduced. The medical coverage policy specific to clinical trials contains the details on the codes that are to be billed when services are provided as part of a clinical trial. In order for claims to be paid properly, a Provider must include these codes on the claims submission.

Disease and Case Management

Disease Management ("DM") Program:

Humana offers several disease-specific programs to provide additional support to Members and their physicians. These programs are designed to complement the physician's treatment plan and empower the Member through education and support. Members identified by the Provider as being candidates for any of the DM programs may be referred by the Provider to the disease management manager by

contacting the local Humana market office or by calling provider relations at 1-800-626-2741. Providers may also refer Members to the DM program directly via the contact information on Humana's website.

Case Management:

Humana Cares Complex Case Management Program assists the most frail and vulnerable Members. This program emphasizes a "Member for life" strategy. Members are not discharged from the program unless they are no longer enrolled in one of Humana's Medicare Advantage products. Care managers continually assess Members' acuity and support them throughout life's course, particularly as new issues arise.

Commercial Complex Case Management ("CCM") is provided by Humana nurses specially trained in case management. Their specialized focus is on Members with complex medical situations or those who have been hospitalized. Management varies by the individual and may include on-site nurse or telephonic support, discharge follow-up support, coordination of services and integrated behavioral health assessment. To refer Commercial Members call 1-800-327-9496.

Medicare/Medicaid Members may also be referred to CCM and DM Programs by calling the Health Services Line at 1-800-322-2758.

Additionally, Providers may call the Humana Health Planning and Support team at 1-800-491-4164 to refer Members to be screened for all clinical programs and all lines of business including, but not limited to, Humana Cares.

Information about Humana's Health and Wellness, DM and Case Management programs, and how to refer Members to the programs are found on Humana.com's Providers section.

Claims Submission and Processing

Claims Submission: Providers using electronic submission must submit all claims to Humana or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") compliant 837 electronic format, or a CMS-1500 and/or UB-04, or their successors. Claims must include the Provider's NPI and the valid taxonomy code that most accurately describes the services reported on the claim. No reimbursement is due for a covered service and/or no claim is complete for a covered service unless Provider's performance of that covered service is fully and accurately documented in the Member's medical record prior to the initial submission of the claim. Furthermore, Members must not be held responsible for any payments to provider except for applicable copayments, coinsurance, deductibles, and noncovered services provided to such Members.

Unless applicable law provides that submissions may be in paper format, Providers must submit all claims, encounters, and clinical data to Humana by electronic means available and accepted as industry standard, which may include claims clearinghouses or electronic data interface companies used by Humana. Provider acknowledges that Humana may market certain products that will require electronic submission of claims and clinical data in order for Provider to participate. Provider must notify Humana when they have completed their transition to Electronic Medical Records and agrees to provide information on the status to Humana upon request. Unless applicable law mandates submission may be in paper format, Provider must submit to Humana all Humana required clinical data (including, but not limited to, laboratory data) by available electronic means within thirty (30) days of the date of service or within the time specified by applicable law.

All claims and encounters resulting in the generation of a lab result require the **Provider** to submit the corresponding lab result electronically to Humana within 30 days of the Member's date of service. The lab result must be submitted electronically in Humana's Standard File Layout (<http://apps.humana.com/marketing/documents.asp?file=2098642>), and include the correct LOINC code (Logical Observation Identifiers Names and Codes) and other values associated with the result in the correct data format

as outlined in Humana's Standard File Layout. Submission must be made through one of Humana's approved methods as outlined on the Humana Provider website. Provider's failure to comply with claims, encounters, and lab results data submission guidelines may result in a reduction of the amount, if any, which would otherwise be due under this Agreement for the service. A reduction in the Capitation Payment amount may be applicable to Capitated Providers.

This data will be used within the guidelines allowed by HIPAA (Health Insurance Portability and Accountability Act) and GINA (Genetic Information Nondiscrimination Act). This data allows Humana to comply with accreditation and regulatory requirements established by CMS, NCQA (National Committee for Quality Assurance), and/or other regulatory agencies. This data may also be used to establish Member clinical profiles, to more easily predict disease progression sooner and reduce acuity, as well as calculate HEDIS® (Healthcare Effectiveness Data and Information Set) qualitative scores, and other member related initiatives.

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

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

Real-Time Claims Adjudication ("RTCA"): This system offers a simplified administrative approach for submitting and processing claims through Availity® LLC. Humana's RTCA process enables a Provider to bill for service before the Member leaves the office and to receive a fully adjudicated response back – at the time of service. (**Note:** The RTCA process may not work for every claim.) With this technology, Providers can instantly see the total and allowable charges, as well as the patient liability amount, such as coinsurance, deductible, etc. Therefore, Providers can collect accurately at the time of service and not have to collect an estimated amount. Contact the Provider Deployment Team or call Humana Customer Service for specific information on the system.

Prompt Payment of Claims: A claim is processed promptly if it is approved or denied within the time required by the Agreement or the applicable regulation of the state in which Humana is operating. For claims to be paid promptly:

- A properly completed claim must be submitted electronically or by paper and the claim must not involve an investigation for coordination of benefits (COB), pre-existing condition investigation, Member eligibility, or subrogation (i.e., a "clean claim").
- A Member's original signature, or "Signature on File" or "Assignment on File" stamp is required for payments made directly to the Provider.

Note: The Provider must maintain a valid written assignment of benefits from the Member on file. This will serve as evidence that the Provider is entitled to all payments for service. Humana reserves the right to review the original signed assignment document at any time.

- Separate charges must be itemized on separate lines. Medical record documentation must validate the scope of services provided and billed.

- The time frame for submitting claims is listed below, if not otherwise specified by the Agreement or applicable state or federal law:
 - **Commercial lines of business:** 180 days from date of service for physicians; 90 days from date of service for facilities and ancillary Providers
 - **Medicare lines of business:** within one (1) calendar year from the date of service

Specialist Providers: For commercial HMO and Medicare Advantage HMO, reimbursement for specialist services is dependent upon referral authorization and corresponding documentation. All specialist claims must include a referral number, when applicable, or an inpatient authorization number and the referral authorization or inpatient authorization number must be shown in Box 23 of the CMS-1500 Claim Form or Box 64 of the CMS-1450 Form. (Also, see Chapter One, Referrals, Section III in this Manual.) If the referral authorization number is not on the claim, the claim may be rejected. The Member may not be balance billed for this type of rejected claim.

Inpatient Specialty Services: All claims for inpatient treatment must include an inpatient authorization number. If the physician is not the admitting physician, the authorization number is obtained from the Member's chart, Member's primary care office, IPA, delegated entity, or Humana Customer Service.

Requests for Review of Denied Claims: Participating Providers may request a review of service or claim payment denials by the Plan(s). To obtain a review, Providers must telephone Humana Customer Service at the number listed on the back of the Member's ID card or send a written request to the appropriate Humana claims address (refer to the Provider Claims Reconsideration section of this Manual).

Coding Edits: Humana will process Provider claims that are accurate and complete in accordance with Humana's normal claims processing procedures and applicable state and/or federal laws, rules and regulations with respect to the timeliness of claims processing. Such claims processing procedures and edits may include, without limitation, automated systems applications which identify, analyze and compare the amounts claimed for payment with the diagnosis codes and which analyze the relationships among the billing codes used to represent the services provided to Members. These automated systems may result in an adjustment of the payment to the Provider for the services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these automated systems by submitting a timely request for reconsideration to Humana (please see the Provider Claims Reconsideration section of this Manual for more information). A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a noncovered service.

Humana provides a summary of the code edits, policy change notification dates, and implementation dates. The list is not intended to be exhaustive but is made available at Humana.com, Providers' section.

Pass-Through Billing: Humana prohibits pass-through billing. Pass through billing occurs when the ordering Provider requests and bills for a service, but the service is not performed by the ordering Provider or those under their direct employ. Provider agrees that services related to pass-through billing will not be eligible for reimbursement from Humana and Provider shall not bill, charge, seek payment or have any recourse against Humana or Members for any amounts related to the provision of pass-through billing.

Reimbursement

Payment terms are defined in the Agreement. The amount of payment for services provided is affected not only by the terms in the Agreement, but also by the following:

- Member's eligibility at the time of service
- Whether services provided are covered services under the Member's Plan
- Whether services provided are medically necessary as required by the Member's Plan
- Whether services were without the prior approval of Humana, if prior approval is required by the Member's Plan
- Amount of the Provider's billed charges
- Member copayments, coinsurance, deductibles, and other cost-share amounts due from the Member and coordination of benefits with third-party payors as applicable
- Adjustments of payments based on coding edits described above

A Provider who receives reimbursement for services rendered to Humana Medicare Advantage Members must comply with all federal laws, rules, and regulations applicable to individuals and entities receiving federal funds, including without limitation Title VI of the Civil Rights act of 1964, Age Discrimination Act of 1975, Americans with Disability Act, and Rehabilitation Act of 1973.

Nothing contained in the Agreement or this Manual is intended by Humana to be a financial incentive or payment which directly or indirectly acts as an inducement for Providers to limit medically necessary services.

Humana applies the CMS site-of-service payment differentials in its fee schedules for CPT® codes based on the place of treatment (physician office services versus other places of treatment).

Surgical Payments: Reimbursement to the surgeon for surgical services includes charges for preoperative evaluation and care, surgical procedures, and postoperative care. The following claims payment policies apply to surgical services:

- **Incidental Surgeries/Complications:** A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for extra payment (e.g., appendectomy during a cholecystectomy). Any complicated procedure that warrants consideration for extra payment should be so identified with an operative report and the appropriate modifier (e.g., excessive hemorrhaging). A determination will be made by a physician reviewer on whether the proposed complication merits additional compensation above the usual allowable amount.
- **Admission Examination:** One charge for an admission history and physical from either the surgeon or the physician will be eligible for payment, which should be coded and billed separately.
- **Follow-up Surgery Charges:** Charges for follow-up surgery visits are considered to be included in the surgical service charge and are not reimbursed separately. Follow-up days included in the global surgical period vary by procedure and are based on CMS policy.
- **Multiple Procedures:** Unless Provider's Agreement indicates otherwise, for commercial products, Humana will pay the primary surgeon 100% of the allowable fee for the primary procedure, 50% for the second procedure, and 25% for each additional procedure. For Medicare products, Humana will pay 100%, 50%, and 50%, respectively. These percentages apply when eligible multiple surgical procedures are performed under one continuous surgical service, or when multiple surgical procedures are performed on the same day and by the same surgeon.
- **Assistant Surgeon:** In most states, Humana pays 20% of the assistant surgeon's contracted rate for the surgery. For Medicare Members, Humana pays 16% of the assistant surgeon's contracted rate. Payment for non-physician practitioner ("NPP") claims for assistant surgery is based on the following:

- Commercial Plans: 10% of the contracted fee schedule. The exception is when the Member's certificate stipulates payment at 20%.
- Medicare Plans: 16% of the NPP's contracted base rate.

Note: It is the participating surgeon's responsibility to select a participating assistant. The above reduction is systematically taken based on the modifier on the claims. Humana only pays for surgical assistants for certain procedures. Humana uses the American College of Surgeons ("ACS") as the primary source to determine which procedures allow an assistant surgeon. For procedures that the ACS lists as "sometimes," CMS is used as the secondary source.

- **Co-Surgeon:** Each co-surgeon receives 62.5% of the allowable fee. Co-surgeons are defined as two surgeons who work together as primary surgeons performing distinct part(s) of a surgical procedure. In these cases, each surgeon should report his/her distinct, operative work by adding the modifier '62' to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier '62' added.

With some claims, additional information may justify additional payment. For example, a Provider's clinical notes may establish that a procedure code initially judged incidental to another in Humana's automated process, actually involved distinct and significant Provider efforts during Provider's encounter with his or her patient.

If a Provider believes that Humana has adjudicated a claim incorrectly, the Provider should follow the procedures set forth in the Coding Edits section above regarding Provider Claims Reconsideration, or, if applicable, any state specific laws. Please include a copy of the applicable clinical notes with the Provider reconsideration request.

Providers must accept payment from Humana for covered services provided to health Plan Members in accordance with the reimbursement terms outlined in the Agreement. Payments made to Providers constitute payment in full by Humana for covered benefits, except with respect to copayments, coinsurance and deductibles, which are the Member's responsibility. These payments made by Humana are net of Member copayments, coinsurance and deductibles. For covered services, Providers may not balance bill Members for a monetary amount over or above the fee schedule provided in their Agreement. The Provider is not prohibited by the Agreement from collecting from health Plan Members for any services not covered under the terms of the applicable Member Plan; however, a Provider may collect from a Humana Medicare Advantage Plan Member for a service not covered under the terms of the applicable Member Plan only if the Provider notified the Member – before providing the service – of an expectation that the Plan might not cover the service and the Provider documented such notification. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

Services Which Are Not Medically Necessary: Provider agrees that in the event of a denial of payment for services rendered to Members determined not to be medically necessary by Humana, that Provider shall not bill, charge, seek payment or have any recourse against Member for such services.

The Following Applies Only to Hospital Reimbursement: Hospital agrees to comply with Humana's hospital Audit and prepayment review Policies which can be found at Humana.com, Providers' section.

IV. Office Procedures

This section provides policies and procedures that pertain to the daily operations of a Provider office.

Office Appointment and Wait Times: In part to coincide with Providers' commitment to assist Humana with its performance and quality management, Providers shall implement procedures and make reasonable efforts to ensure that:

- Members are seen by a clinician within 15 minutes of the Member's appointment time.
- Routine and follow-up appointments are made within 30 calendar days
- Urgent appointments are made within 24 hours
- Urgently needed services must be provided immediately for Medicare Members
- Emergent appointments are made immediately (arrange for on-call or after-hours coverage)

Please see **Preauthorization and Notification (Utilization Management)** in Section III and Section X of this Manual, **Quality/Disease Management**, below, for more details.

Medical Records: Humana Provider representatives must be permitted access to the Provider's office records and operations. This access allows Humana to monitor compliance with regulatory requirements. Each Provider office will maintain complete and accurate medical records for all Humana Members receiving medical services in a format and for time periods as required by the following:

- Applicable state and federal laws
- Licensing, accreditation, and reimbursement rules and regulations to which Humana is subject
- Accepted medical practices and standards

Note: Humana has adopted guidelines based on federal and state medical record documentation requirements. These are available at Clinical Practice Guidelines/Providers on Humana.com.

The Provider's medical records must be available for utilization, risk management, peer review studies, customer service inquiries, grievance and appeal processing, claims reconsideration and other initiatives Humana may be required to conduct. To comply with accreditation and regulatory requirements, Humana may periodically perform a documentation audit of some Provider medical records. The Provider must meet 85% of the requirements for medical record keeping with a goal of 90%, or per applicable state and federal requirements if more stringent.

The participating Provider must respond to the Humana Member grievance and appeal unit expeditiously with submission of the required medical records to comply with time frames established by CMS and/or the state department of insurance for the processing of grievances and appeals. Only those records for the time period designated on the request should be sent. A copy of the request letter should be submitted with the copy of the record. The submission should include test results, office notes, referrals, telephone logs and consultation reports. Medical records should not be faxed to the local Humana market office unless Provider can ensure confidentiality of those medical records.

To be compliant with HIPAA, Providers should make reasonable efforts to restrict access and limit routine disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose of the disclosure of Member information.

For HMO Plans, if a Plan Member changes his/her PCP for any reason, the Provider must transfer a copy of the Member's medical record to the Member's new PCP at the request of the Plan or the Member. The Agreement states whether the original or a copy of the medical record must be sent. If a Provider terminates, the Provider is responsible for transferring the Members' medical records.

Charges for copying medical records are considered a part of office overhead and are to be provided at no cost to Members and Humana, unless state regulations or the Agreement stipulate otherwise.

Initial Determination is defined as the Plan's/Humana's or contracted Provider's first decision regarding a request for coverage of a service or additional benefits concerning:

- Reimbursement for emergency services (either in or out of the service area), urgently needed services outside of the service area, post stabilization care, or out-of-area renal dialysis.
- Services from a Provider not under contract with the Plan which the Member believes are covered under Medicare and should have been authorized for coverage by the Plan.
- Refusal to authorize coverage for services which the Member believes to be covered in whole or in part, including the type or level of services.
- Discontinuance of coverage for a service if a Member disagrees that the service is no longer medically necessary.
- Failure to provide payment for health care services in a timely manner or failure to provide the Member with timely notice of an adverse coverage determination (if the delay would adversely affect the Member's health).

Initial determinations may be made by one of the following:

- PCP/primary care office
- Claims unit
- Delegated entities
- HumanaHealth department areas (transplant, bariatric, NICU, market referral units, and market clinical departments)

Initial determination decisions should be rendered as expeditiously as the Medicare Advantage Member's health condition requires, but no later than 14 calendar days from the date of request. Requests not acted upon within 14 calendar days constitute an automatic expedited initial organizational denial and may be appealed by the Medicare beneficiary without further delay.

V. Member Grievance/Appeal Process, Provider Claims Reconsideration Process & Provider Termination Appeal Process

A. Member Grievance/Appeal Process

The grievance/appeal process applies to **Members** of commercial group Plans and Medicare Advantage Members who are dissatisfied with the health care services received, **or any aspect of the Plan**. A commercial group Plan grievance/appeal may be filed by a current or former Member or his/her authorized representative. Unless otherwise mandated by state law, Providers for commercial group Members may utilize the Member's grievance/appeal process by obtaining written authorization from the Member.

A Medicare Plan grievance may be filed by current or former Member or his/her authorized representative.

A Medicare Advantage Plan Member, representative, physician or non-participating Provider may appeal preservice denials and the following post-service denials with a Provider reconsideration waiver:

- Full claim denials
- Claims paying zero dollars
- Claims denied for medical necessity
- Claims denied for noncovered benefits

A Medicare Prescription Drug Plan (“PDP”) Member, representative, the prescribing physician, or other prescriber may appeal. The Member’s prescribing physician and other prescribers have the right to file a standard redetermination request on behalf of the Member as long as the Member is notified. An Appointment of Representative (“AOR”) is not required.

Humana will accept Members’ and/or Providers’ requests for expedited/urgent appeals for both commercial and Medicare Advantage Members and by prescribing physicians if the Member is a Medicare Part D Plan Member. The Member’s treating physician has the right to file a standard pre-service appeal request on behalf of the Member as long as the Member is notified and an AOR is not required for MA Plan Members. Also, certain states and federal programs may have specific processes for physician grievance/appeal requests. The grievance/appeal process for Members is an internal process designed to resolve complaints or disputes regarding adverse determinations. If the initial grievance/appeal is upheld, the resolution letter will provide next level rights as applicable. Additional details regarding commercial and Medicare Advantage appeals on behalf of Members are set forth below.

Commercial Appeals

Commercial Appeals Definitions of Terms:

Adverse Determination: A denial, reduction, termination of, or failure to provide **a service** or make payment:

- In whole or part for a benefit (Example: Applying the Plan provisions and paying less than the total amount of expense submitted for a deductible, coinsurance or copayment)
- For Group Plans: Based on eligibility to participate in the Plan (when a claim or appeal is made)
- For Individual Plans: Based on eligibility to participate in the Plan
- Based on rescission of coverage

Expedited/Urgent Appeal: a verbal or written request for a fast or rush appeal from a Member, representative, or physician to appeal a service denial, termination of care, or a reduction in the level of care. An appeal will be expedited when the determination, if processed according to the standard appeal time frames, could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function, or would cause the member to have severe pain that cannot be adequately managed without the requested care or treatment.

Independent/External Review Organization (IRO): An external company designated to provide an independent review, either affiliated with a state agency or an external review entity contracted by Humana to independently review appeals upon request.

Second-Level Appeal: A formal request for reconsideration of an appeal of an adverse determination. If the Member submits an appeal and the denial is upheld following the review, the Member may be eligible to request a second level appeal depending upon the Member’s specific benefits and/or state regulatory requirements.

Specialty Review: A review conducted by a health care Provider that typically manages the medical condition, procedure, or treatment under review for clinical appeals.

Standard Appeal: A formal request for reconsideration of an adverse determination.

Commercial Appeals Process

Humana will accept and process any oral or written appeal from a Member or the Member's authorized representative expressing dissatisfaction with Humana's adverse determination. Verbal appeals are accepted if required by the state or for reasons of illiteracy, handicap, or if the Member is too ill to write.

If the initial determination is upheld, the resolution letter from Humana will provide the appropriate information to file an expedited or standard appeal.

Appeals may include:

- Medical necessity denials;
- Benefit denials;
- Claim denials that affect the payment of a deductible, coinsurance or copayment;
(**Note:** claim denials are not subject to the expedited appeal process.)
- Termination or reduction of care or benefits; or
- Delays in providing or approving coverage or services when a delay would adversely affect the Member's health

Humana will identify and remove any communication barriers that may impede Member from effectively making appeals. Humana will facilitate the request to file an appeal for a Member who has a communication challenge affecting his/her ability to communicate or read through the following means:

- The TTY line is available for the hearing impaired;
- A translation service will be used for Members unable to speak English if an in-house translator is not available; and
- Additional accommodations will be made for any Member with special needs who is unable to follow the standard process

Humana will provide a full and fair review of the appeal. All appeal reviews will be conducted by a reviewer possessing the following characteristics:

- Did not participate in the initial decision; and
- Is not a subordinate of the individual who made the initial decision

In addition to the above requirements, appeal reviews for medical necessity, experimental, and investigational will include a specialty review by a reviewer who is from the same or similar specialty, who typically treats the medical condition or provides the treatment in question, and holds an active, unrestricted medical license.

Appeals should be submitted within 180 days of the date that Member receives the adverse determination (see Note 1 below). Member may provide Humana with additional information that relates to the adverse determination and Member may request copies of information that Humana has that pertains to the appeal. Humana will notify Member of its decision within 72 hours for expedited appeals or within 30–60 days for standard appeal of receiving the request (see Note 2 below).

Note 1: Unless Member's Plan or any applicable state law allows additional time.

Note 2: Some states or Plans allow more (or less) time for Humana's decision. See Member's benefit Plan document for any state or Plan specific appeal time frames or processes.

Procedures for Additional Level for Commercial Appeals

If the appeal is upheld, some states or Plans may allow for a second level and/or a review by an Independent Review Organization. The resolution letter for the first level appeal will provide specific information regarding additional levels of review available to Members.

Medicare Appeals

Medicare Appeals – Definition of Terms:

Authorized Representative - an individual either appointed by a Member or authorized under state or other applicable law to act on behalf of the Member in obtaining an organization/coverage determination, or grievance or appeal determination.

Coverage Determination (Part D Plan) - any decision made by or on behalf of a Part D Plan regarding payment or benefits to which a Member believes he or she is entitled.

Expedited/Urgent Appeal - A verbal or written request for a fast appeal review of a preservice denial, termination of care, or a reduction in the level of care if the time frame for a standard appeal could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, or care or treatment that if not rendered could subject the Member to severe pain that cannot be adequately managed, based on the opinion of a practitioner with knowledge of the Member's medical condition. Expedited appeals exclude requests for payments for services already provided.

Independent Review Entity ("IRE") - an independent entity contracted by CMS to provide an independent review of a Plan's appeal decision.

Organization Determination (MA Plan) - any determination made by a Medicare health Plan with respect to any of the following:

- Payment for temporarily out-of-the-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a Provider other than the Medicare health Plan that the Member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for or reimbursed by the Medicare health Plan;
- The Medicare health Plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged by the Medicare health Plan;
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
- Failure of the Medicare health Plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the health of the Member; or
- Medicare Savings Accounts (MSA) only; decisions regarding whether expenses paid for with money from the MSA bank account or paid for out of pocket, constitute Medicare expenses that count towards the deductible; and, prior to satisfying the deductible, decisions as to the amount the Member had to pay for a service

Reconsideration (MA appeal) - the first step in the appeal process after an adverse organization determination; A Medicare health Plan or independent review entity may reevaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

Redetermination (PDP appeal) - the first level of the appeal process which involves a Part D Plan reevaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.

Specialty Review - a review conducted by a health care provider that typically manages the medical condition, procedure, or treatment under review for clinical appeals.

Medicare Appeals Process:

Humana will accept and process any oral PDP or written PDP or Medicare Advantage appeal from a Member or an authorized representative expressing dissatisfaction with Humana's adverse determination. In addition, Humana will accept and process any additional evidence or allegations of law and fact related to the disputed issue.

Expedited appeals exclude requests for payments of services already provided, but may include:

- medical necessity (service) denials;
- benefit denials;
- termination or reduction of care or benefits; or
- delays in providing or approving an expedited coverage or service request when a delay would adversely affect the Member's health

Standard appeals may include:

- medical necessity denials;
- benefit denials;
- claim denials that affect the member's payment of a deductible, coinsurance or copayment;
- termination or reduction of care or benefits; or
- delays in providing or approving coverage or services when a delay would adversely affect the member's health

Humana will identify and remove any communication barriers that may impede Members or representatives from effectively making appeals. Humana will facilitate the request to file an appeal for a Member who has a communication challenge affecting his/her ability to communicate or read through the following means:

- The TTY line is available for the hearing impaired;
- A translation service or in-house translator will be used for Members unable to speak English; and
- Additional accommodations will be made for any Member with special needs who is unable to follow the standard process

If the initial determination is upheld, the resolution letter from Humana will provide the appropriate instructions to file an expedited or standard appeal.

Humana will provide a full and fair review of the appeal including specialty review for clinical appeals. Appeals must be submitted within 60 calendar days from the date of the adverse determination notice, unless the Member can demonstrate good cause.

Medicare Advantage Plans: Notification of the decision will be issued within the following time frames from the date of receipt of the request:

- Expedited - As expeditiously as the Member's health condition requires, but no later than 72 hours
- Preservice - As expeditiously as required based on the Member's health, but no later than 30 calendar days; or
- Post-service - 60 calendar days

Time frames for decisions may be extended for expedited and preservice appeals if the:

- Member requests the extension; or
- Humana justifies the necessity for additional information and documents that it is in the best interest of the Member

The extension notification to the Member must occur prior to the expiration of the decision time frame and must include the right to file an expedited grievance if the Member disagrees with the extension.

Medicare Prescription Drug Plans: Notification of the decision will be issued within the following time frames from the date of receipt of the request:

- Expedited - As expeditiously as the Member's health condition requires, but no later than 72 hours; or
- Standard - Seven (7) calendar days

Procedures for Second Level Medicare Advantage Appeals

Humana will forward the following appeals to the IRE contracted by CMS in the following circumstances:

- Decision not fully in the Member's favor;
- Failure to meet the decision time frames; or
- Dismissals due to:
 - Lack of authorized representative documents; or
 - Humana discovered that the service has already been obtained and the expedited appeal had already been submitted to the IRE

B. Provider Claims Reconsideration Process

For All Products:

If, upon receipt of an initial claim determination from Humana via Explanation of Benefits or Automated Remittance Advice, the Provider disagrees with the determination made by Humana and would like to request a reconsideration/reopening of the issue, Providers may do so by contacting Humana in one of two ways. The first is by telephone, and the second is via written correspondence. Members can have specific addresses or telephone numbers associated with their membership, so it is best to utilize the contact information located directly on the back of ID card of the Member in question. If the Provider does not have this information, Providers may contact Humana via the general phone number or mailing address:

Phone: 1-800-4-HUMANA
 Address: Humana Correspondence
 PO Box 14601
 Lexington, KY 40512

When sending in a written request for reconsideration/reopening the following information must accompany the request: Provider name and tax ID, Member name and identification number, date of service, relationship of the Member to the patient, claim number, name of the provider of services, charge amount, payment amount, and a brief description of the basis for the contestation. In addition,

be sure to include any relevant supporting documentation (medical records, copy of invoice, etc.). All Provider requests for Claims Reconsiderations must be received by Humana within 18 months of the date the claim was paid unless state or federal law or the Agreement require another time period or the claim will not be reopened or reconsidered.

If the Provider is unsatisfied with the determination made on the phone call, or upon receipt of the determination made by Humana's Claims Research Unit or Correspondence Team that completed the review, they may submit a request for a second reconsideration/reopening to humanaproviderservices@humana.com. The Humana Provider Services Team reviews escalated issues when Providers are unable to get resolution to reconsiderations/reopenings via normal submission methods. Providers will need to include the Member's information, claim information, the reference ID numbers provided on previous contacts to Humana, and any other relevant information to the review (medical records, copy of invoice, etc.). Within 48 hours of email submission, the Provider will receive a reference ID number that they may use to contact Customer Service to receive status of the review at any time.

Note: The above provisions of this section are to be considered as separate and distinct from the arbitration provisions set forth in Provider's Agreement.

C. Provider Termination Appeal Process

Note: The following termination appeal process is to be considered in conjunction with the termination rights set forth in Provider's Agreement and, where applicable, state and federal law and regulations.

Medicare Advantage

In accordance with Medicare regulations found at 42 C.F.R. §422.202, Providers have the right to a review of a termination decision by a Physician Review Panel. The Provider must submit a written request for this panel review within 30 calendar days of the date of notice of termination or Provider's rights to this review will be waived.

The request must be addressed to the party identified in the termination notice letter and must be sent by either registered or certified mail. The request should include any relevant written information to be considered by the Physician Review Panel. However, the Physician Review Panel will consider only the written information submitted. The review will be held prior to the effective date of this termination. The Physician Review Panel shall present a written decision to the Provider via certified or registered mail.

Commercial Plans

Unless otherwise mandated by state law or regulations, or the Agreement, the above Provider termination appeal process applies only to Medicare Advantage Providers.

VI. Covered Services

A service must be medically necessary and covered by the Member's contract to be paid by the Plan. The Plan determines whether services are medically necessary as defined by the Member's certificate of coverage. To verify covered or excluded services, call Humana Customer Service at the number listed on the back of the Member's ID card, or verify benefits on Humana.com or Availity.com. All services may be subject to applicable copayments, deductibles, and coinsurance.

Humana uses the current nationally approved criteria for any medical necessity reviews required.

Humana makes coverage determinations, including medical necessity determinations, based upon its Members' certificates of coverage. However, Humana is not a provider of medical services and it does not control the clinical judgment or treatment recommendations made by the Provider in its networks or who may otherwise be selected by Members. Providers make independent health care treatment decisions.

VII. Clinical Practice Guidelines

Humana provides Web links to clinical practice guidelines developed by nationally recognized organizations, which are reviewed and updated accordingly. The guidelines are available at Humana.com, Providers' section.

VIII. Compliance/Ethics

Liability Insurance

zUpon request, all Providers must provide Humana with evidence of insurance coverage in accordance with their Agreement's requirements.

General Compliance and Fraud, Waste and Abuse Requirements

Contracted Providers are responsible for complying with all applicable laws, regulations and Humana's policies and procedures, including, but not limited to, Humana's Compliance Policy for Health Care Providers and Business Partners ("Compliance Policy"), Principles of Business Ethics for Health Care Providers and Business Partners ("PBE") and Humana's Fraud, Waste and Abuse ("FWA") requirements outlined in Humana's FWA training. All of these documents are available on Humana's website.

These documents incorporate requirements outlined by CMS for all sponsors of Medicare Advantage or Prescription Drug Plans and any individuals and entities that provide administrative support, related materials/supplies and/or render services for sponsors' Plans, as detailed in Chapter 21 of the Medicare Managed Care Manual, and Chapter 9 of the Prescription Drug Benefit Manual.

Humana's general compliance and FWA requirements for contracted Providers, regardless of their participation in a Humana Medicare Plan, include, but are not limited to:

1. Being familiar with Humana's compliance expectations and requirements relating to FWA, which have been outlined in Humana's FWA training, Compliance Policy and PBE.
2. Monitoring the compliance of employees.
3. Monitoring and auditing the compliance of Subcontractors that provide services or support related to administrative or health care services provided to a Member of a Humana Medicare Advantage or Prescription Drug Plan ("Downstream Entities").
4. Obtaining approval from Humana for any relationships with Downstream Entities. In addition, note that Humana must notify CMS of any location outside of the United States or a United States territory that receives, processes, transfer, stores or accesses Medicare Member protected health information in oral, written or electronic form.

5. Reporting instances of suspected and/or detected FWA.
6. Having policies and procedures in place for preventing, detecting, correcting and reporting FWA, including, but not limited to:
 - a. Requiring employees and Downstream Entities to report suspected and/or detected FWA;
 - b. Safeguarding Humana's confidential and proprietary information;
 - c. Providing accurate and timely information/data in the regular course of business; and
 - d. Screening all employees and Downstream Entities against federal government exclusion lists, including the Office of Inspector General ("OIG") list of Excluded Individuals and Entities and the General Services Administration ("GSA") Excluded Parties Lists System. (Anyone listed on one or both of these lists is not eligible to support Humana's Medicare Advantage and Prescription Drug Plans, must be removed immediately from providing services or support to Humana, and Humana must be notified upon such identification).
7. Cooperating fully with any investigation of alleged, suspected or detected violation of the Manual, Humana policies and procedures, or applicable state or federal laws or regulations, and/or remedial actions.
8. Administering compliance and FWA training to employees and Downstream Entities including, but not limited to:
 - a. Documenting that training requirements have been met; and
 - b. Having a system in place to collect and maintain records of compliance and FWA training for a period of at least 11 years.
9. Instituting disciplinary standards and taking appropriate action upon discovery of FWA or actions likely to lead to FWA.
10. Publicizing disciplinary standards to employees and Downstream Entities.
11. Avoiding conflicts of interest and providing Humana with conflict of interest statements covering the Provider, employees and Downstream Entities.

Additional information can be found in Humana's Compliance Policy, PBE, and FWA training.

Reporting Methods for Suspected or Detected Noncompliance

Contracted Providers, their employees, and related entities are required to notify Humana's Special Investigations Unit ("SIU") of suspected or detected FWA. Information about SIU and Humana's efforts to prevent and detect fraud can be found on Humana's website (<http://www.humana.com/about/fraud>) and in Humana's PBE, Compliance Policy, and FWA training.

Providers, their employees, and Downstream Entities may also report concerns and information related to FWA and noncompliance with this Manual, Humana's PBE, and/or Compliance Policy to Humana via a number of anonymous options:

Humana Special Investigations Unit Direct Line: 1-800-558-4444, ext. 8187 (M-F, 8 am - 5:30 pm EST);
Humana Special Investigations Hotline (voice messaging system): 1-800-614-4126 (24/7 access);
Humana Ethics Help Line: 1-877-5-THE-KEY (1-877-584-3539); or Email: siureferrals@humana.com or ethics@humana.com; Web: www.ethicshelpline.com

Individuals and entities that report suspected or detected false claims violations are protected from retaliation under 31 U.S.C. 3730(h) for False Claims Act complaints. Humana has a policy of non-retaliation against those who in good faith report suspected or detected violations of Humana's policies and has zero tolerance for retaliation or retribution against any person who reports suspected misconduct.

Once SIU performs its initial investigation, SIU may refer the case to the appropriate law enforcement and/or regulatory agencies (including, but not limited to, the appropriate CMS regional office) as SIU deems appropriate.

Disciplinary Standards

Confirmed FWA violations by health care Providers and/or Humana's Downstream Entities could result in any or all of the following:

- Oral or written warnings or reprimands;
- Suspensions or termination(s) of employment or Agreement;
- Other measures which may be outlined in the Agreement;
- Mandatory retraining;
- Corrective action plan(s); and/or
- Reporting of the conduct to the appropriate external entity(s), such as CMS, a CMS designee, and/or law enforcement agencies.

Reporting Occurrences

An occurrence is defined as any unforeseen complication or unusual event in which a Member of a Humana health Plan is involved ("Occurrence"). Examples of an Occurrence include:

- Unexpected death of a Member at the Member's home, office, or public place, particularly after a recent visit to the Provider's office or facilities;
- Any complication related to a drug, treatment, or service prescribed;
- Dissatisfaction angrily expressed by a Member or their representative with threats related to medical care rendered by the Provider;
- Breach of confidentiality and/or inappropriate release of Protected Health Information (as defined under the Health Insurance Portability and Accountability Act);
- Requests for medical records by an attorney if the request is related to a potential medical negligence claim (Note: This does not cover medical records requests for workers' compensation and/or motor vehicle accidents); and/or
- Adverse outcomes to a Member as a result of:
 - surgery (such as brain or spinal damage)
 - delayed scheduling or completing of diagnostic test or procedure
 - delay in diagnosis or referral process
 - delay in reporting abnormal results
 - diagnostic procedure
 - prescribed medications (e.g., wrong drugs dispensed)
 - any drug, treatment, or service prescribed
 - surgical error and/or surgical procedure being performed on the wrong patient
 - surgical procedure unrelated to the patient's diagnosis
 - transplant management

Providers are expected to report any Occurrence that happens to a Plan Member when visiting their offices, except for Occurrences that take place in acute care, skilled nursing or rehabilitation facilities. Reporting Occurrences inside acute care, skilled nursing and rehabilitation facilities is dictated by the operational procedures of each facility.

Report all Occurrences to Humana as soon as possible, preferably within three (3) business days of the Occurrence. Occurrence Reports for Humana Health Plan Members can be reported to: RiskManagementAdministration@humana.com, or by contacting provider relations at 1-800-626-2741.

Note: In the state of Florida, Occurrences must be received by the Humana risk manager within three (3) calendar days, per Florida statute F.S. 59A-12.012. The information submitted to the health Plan is used for state mandated risk management review. All information reported to the health Plan will remain strictly confidential in accordance with Humana’s policy and procedure on confidentiality.

Conflicts of Interest

All contracted Providers, their employees and Downstream Entities are required to avoid conflicts of interest. Providers should never offer or provide anything of value – including, but not limited to, cash, bribes or kickbacks – to any Humana associate, representative or customer or government official in connection with any Humana procurement, transaction or business dealing. This prohibition also applies to any family members or significant others.

Contracted Providers are required to obtain conflicts of interest statements from all employees and Downstream Entities within 90 days of hire or contract, and annually thereafter. This statement must certify that the employee or Downstream Entity is free from any conflict of interest which would prevent them from administering or delivering Medicare benefits or services. All Providers are required to review potential conflicts of interest and either remove the conflict or, if appropriate, obtain approval from affected parties to continue work despite the conflict.

Humana reserves the right to obtain certifications from all Providers and to require that certain conflicts be removed, or that the applicable individuals or entities be removed from supporting Humana.

Providers are prohibited from having any financial relationship relating to the delivery of or billing for Covered Services that:

- Would violate the federal Stark Law, 42 U.S.C. § 1395nn, if health care services delivered in connection with the relationship were billed to a federal health care program; or that would violate comparable state law;
- Would violate the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, if health care services delivered in connection with the relationship were billed to a federal health care program; or that would violate comparable state law; or
- In the judgment of Humana, could reasonably be expected to influence Provider to utilize or bill for Covered Services in a manner that is inconsistent with professional standards or norms in the local community

Providers are subject to termination by Humana for violating this prohibition. Humana reserves the right to request such information and data as it may be required to ascertain ongoing compliance with these provisions.

Medicare

Medicare Marketing Literature and Provider Sponsored Activities: For purposes of this Manual, the term “Medicare Marketing” includes any information, whether oral or in writing, that is intended to promote or educate prospective or current Humana Medicare Advantage or Prescription Drug Plan Members about Humana or its Medicare plans, products or services. This includes, but is not limited to, any and all promotional materials used at Provider-sponsored activities, such as open houses, health fairs and grand openings. Examples of promotional materials include letters, advertisements, invitations, and announcements which use Humana’s name. Medicare Marketing must be approved through the Humana Corporate Review Process prior to a Provider conducting any Medicare Marketing activity. The Humana Corporate Review Process includes review by legal and regulatory compliance and filing through Humana’s Medicare product compliance department and CMS (as applicable), in accordance with CMS

guidelines. To obtain approved Medicare Marketing materials or to arrange for a Provider-sponsored activity, contact the Medicare sales director in the local Humana market office, marketing sales support specialist or the Marketing Director. Any misrepresentation of a Humana Medicare product or service, intentional or not, is a serious violation of Humana's agreements with CMS.

Provider Affiliations: Providers may announce new or continuing affiliations for specific sponsors of Medicare Advantage or Prescription Drug Plans through general advertising, (e.g., radio, television, websites). New affiliation announcements are for those Providers that have entered into a new contractual relationship with the sponsor of a Medicare Advantage or Prescription Drug Plan. Providers may make new affiliation announcements within the first 30 days of the new contract agreement. An announcement to patients of a new affiliation which names only one Medicare Advantage Plan may occur only once when such announcement is conveyed through direct mail, email, or phone. Additional direct mail and/or email communications from Providers to their patients regarding affiliations must include a list of all plan sponsors with which the Provider contracts. Any affiliation communication materials that describe Plans in any way, (e.g., benefits, formularies) must be approved by Humana and CMS.

Medicare HMO and PPO Coverage/Liability: If a **Medicare HMO Member** disenrolls from a Medicare Advantage Plan while in a SNF, costs for SNF services are covered by a new health plan or Medicare as of the effective date of the disenrollment. If a Humana Medicare Advantage Member's effective date of disenrollment occurs while the Member is hospitalized (including, but not limited to, hospitalization in a rehabilitation hospital and long-term care facility), Humana is responsible for paying the contracted rate through the date of discharge, unless otherwise specified in the Agreement.

As long as the **Medicare Advantage HMO Member** resides in the service area, he/she is covered for services until the effective date of disenrollment. When a Member is temporarily out of the service area (for up to six months), coverage is limited to urgently needed, emergency care, post-stabilization services following an emergency, and renal dialysis until the member returns to the service area or the effective date of disenrollment. **Medicare Advantage PPO Members** may receive participating benefits from any participating Provider, nationwide, as well as out-of-network benefits.

Medicare Disenrollment for Cause: CMS guidelines allow a PCP to request a Member's disenrollment "for cause" only if the Member's behavior is disruptive, unruly, abusive, threatening or uncooperative to the extent that his/her continued membership would substantially impair the Provider's ability to provide health services to that particular Member or other patients. A Member may also be disenrolled for other reasons including, but not limited to, if he/she fails to qualify for Medicare benefits, or fraudulently permits others to use his/her Member ID card for services.

A Member cannot be disenrolled based on the Member's utilization (or lack of use) of services or because of mental or cognitive conditions (including mental illness and developmental disabilities), disagreement with a Provider regarding treatment decisions, or as retaliation for a Member's complaint, appeal or grievance. Before initiating a request to disenroll a Member for cause, the Provider and Humana must make a serious effort to resolve the problems, such as encouraging the Member to change his/her behavior, and must document the result of this action. If the behavioral problems are not resolved, the Provider may initiate a request to disenroll the Member by submitting the Request for Disenrollment for Cause form to the local Humana market office. The form is available through the local Humana market office or by calling Humana provider relations at 1-800-626-2741. CMS requires Humana to notify a Medicare Member that the consequences of continued disruptive behavior could include disenrollment from the Plan. **The health Plan and Provider must reasonably demonstrate that the Member's behavior is not related to the use of prescribed medications, mental illness or cognitive conditions (including mental illness and developmental disabilities), treatment for a medical condition, or use (or lack of use) of the Provider's medical services.**

Procedure for Requesting Disenrollment: A written Request for Disenrollment for Cause letter must be sent to the local Humana market office along with supporting documentation as follows:

- Description of the Member's age, diagnosis, mental status, functional status, and social support systems
- Complete and detailed description of the Member's behavior
- Efforts taken to resolve any problems and modify behavior
- Any extenuating circumstances
- Summary of the case and reason for disenrollment
- Copy of medical records
- Statements, as applicable, from other providers, office staff, Members, or law enforcement agencies describing their experiences with the Member

Upon receipt, a Letter Confirming Receipt of Disenrollment Request is sent to the PCP. The information is reviewed for completeness and compliance with the Medicare Member's Evidence of Coverage or the commercial Member's certificate of coverage. If the issues are resolved, the request may be withdrawn.

If the request is deemed to have merit, it is forwarded to a health Plan medical director for review and a decision. The Provider is notified of the decision and may appeal the decision by resubmitting the request along with additional supporting documentation for a subsequent review.

If the Member is a Medicare Member, CMS requires the Plan to notify the Member of its intent to request CMS permission to disenroll the Member and the Plan's grievance procedures. The Plan then notifies CMS and CMS makes the final decision on whether to allow disenrollment for cause of the Member.

If the Member is a commercial Member, Humana works with the benefits administrator of the employer group to make a decision regarding disenrollment for cause. If the decision is made to disenroll the Member for cause, Humana's director of customer service in the appropriate service center will notify the Member by letter of the decision.

Member's Right to Report a Grievance: The Member may request a review of the disenrollment decision by filing a grievance in writing.

Member Disenrollment: The disenrollment is effective the first day of the calendar month after the month in which the health Plan gives the Member written notice of the disenrollment, or as provided by CMS. The Member remains the responsibility of the PCP until the Member's effective date of disenrollment.

Specific Medicare Advantage Plan Requirements:

Providers must remain neutral when assisting with enrollment decisions and may not:

- Offer sales/appointment forms;
- Accept Medicare enrollment applications;
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific Plan based on financial or any other interests of the Provider;
- Mail marketing materials on behalf of Plan sponsors;
- Offer anything of value to induce Plan enrollees to select them as their Provider;
- Offer inducements to persuade beneficiaries to enroll in a particular Plan or organization;
- Conduct health screening as a marketing activity;
- Accept compensation directly or indirectly from the Plan for beneficiary enrollment activities; or
- Distribute materials/applications within an exam room setting.

Providers may:

- Provide the names of Plan sponsors with which they contract and/or participate;
- Provide information and assistance in applying for the Low-Income Subsidy;
- Make available and/or distribute Plan marketing materials;
- Refer patients to other sources of information, such as SHIPs, Plan marketing representatives, their state Medicaid office, local Social Security office, CMS' website at <http://www.medicare.gov/> or 1-800-MEDICARE; and/or
- Share information with patients from CMS' website, including the "Medicare and You" handbook or "Medicare Options Compare" (from <http://www.medicare.gov/>), or other documents that were written by or previously approved by CMS.

Humana is responsible for including certain CMS Medicare Advantage related provisions in the policies and procedures distributed to the Providers that constitute Humana's health services delivery network. The following table summarizes these provisions, which may be accessed online by viewing the Code of Federal Regulations which is available on the U.S. Government Printing Office website (gpo.com):

Summary of CMS Requirement	CFR 42 (Section)
Safeguard privacy and maintain records accurately and timely	422.118
Permanent "out of area" members to receive benefits in continuation area	422.54(b)
Prohibition against discrimination based on health status	422.110(a)
Pay for emergency and urgently needed services	422.100(b)
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)
Direct access to mammography and influenza vaccinations	422.100(g)(1)
No copy for influenza and pneumococcal vaccines	422.100(g)(2)
Agreements with Providers to demonstrate "adequate" access	422.112(a)(1)
Direct access to women's specialists for routine and preventive services	422.112(a)(3)
Services available 24 hrs/day, 7 days/week	422.112(a)(7)
Adhere to CMS marketing provisions	422.80(a), (b), (c)
Ensure services are provided in a culturally competent manner	422.112(a)(8)
Maintain procedures to inform members of follow-up care or provide training in self-care as necessary	422.112(b)(5)
Document in a prominent place in medial record if individual has executed advance directive	422.128(b)(1)(ii)(E)
Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)
Continuation of benefits provisions (may be met in several ways, including contract provision)	422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)
Payment and incentive arrangements specified	422.208
Subject to applicable federal laws	422.504(h)
Disclose to CMS all information necessary to (1) administer & evaluate the program (2) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services	422.64(a): 422.504(a)(4) 422.504(f)(2)
Must make good faith effort to notify all affected members of the termination of a Provider contract 30 calendar days before the termination by Plan or Provider	422.111(e)

Submission of data, medical records and certify completeness and truthfulness	422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)
Comply with medical policy, Quality Improvement and Medical Management	422.202(b); 422.504(a)(5)
Disclose to CMS quality & performance indicators for Plan benefits re: disenrollment rates for beneficiaries enrolled in the Plan for the previous two years	422.504(f)(2)(iv)(A)
Disclose to CMS quality & performance indicators for the benefits under the Plan regarding enrollee satisfaction	422.504(f)(2)(iv)(B)
Disclose to CMS quality & performance indicators for the benefits under the Plan regarding health outcomes	422.504(f)(2)(iv)(C)
Notify Providers in writing for reason of denial, suspension & termination	422.202(d)(1)
Provide 60-day notice (terminating contract without cause)	422.202(d)(4)
Comply with federal laws and regulations to include, but not limited to: federal criminal law, the False Claims Act (31 U.S.C. et Seq.) and the anti-kickback statute (section 1128B(b) of the Act)	422.504(h)(1)
Prohibition of use of excluded practitioners	422.752(a)(8)
Adhere to appeals/grievance procedures	422.562(a)

IX. Product/Plan Overview

Health Maintenance Organization (HMO)

Health Maintenance Organization (“HMO”) Plans require Members to select a PCP to coordinate their care, but non-HMO Plans may also require or recommend that Members see a PCP. A PCP is usually from one of three disciplines:

- Family Physician - A physician who specializes in the care of all members of a family regardless of age.
- Internist - A physician who specializes in internal medicine and gives nonsurgical treatment of medical conditions.
- Pediatrician - A physician who specializes in the development, care, and diseases of children
- Note: In some states, an OBGYN who so elects may also qualify as a PCP.

Note: In certain circumstances, a Certified Nurse Practitioner may be designated as a “NP-PCP” when the state regulations do not prohibit or set limitations on their scope of responsibility. In these cases, the NP-PCP must be fully credentialed and contractually agree to assume responsibilities of a PCP for assigned Members and comply with the terms and conditions of the Agreement and this Manual.

The HMO PCP agrees to accept Plan Members as stipulated by the Agreement. The PCP must not refuse new Members until such time he/she can reasonably demonstrate to the Plan that his/her panel size has reached its maximum for adding new Members. Further, the closing of the PCP’s practice to new Members must be applicable to all third-party payors with whom the PCP contracts. Signed attestations, regarding the size and adequacy of the physician panel, may be required.

Note: The HMO PCP is responsible for arranging for care in his/her absence.

Note: The attending physician should be credentialed by Humana.

Access Standards: In order to comply with the requirements of CMS, accrediting and regulatory agencies, Humana has adopted certain standards for participating physicians that are summarized below. The purpose of these standards is to ensure that health services are available and accessible to Members.

Required for Medicare Providers and Recommended for all other Providers:

Covered services must be geographically accessible and consistent with local patterns of care, ensuring that no Member residing in the service area must travel an unreasonable distance to obtain covered services. The following services must be available in the Plan's service area:

- Medical coverage 24 hours a day, seven (7) days a week
- Urgent but nonemergent appointments within 24 hours
- Urgently needed services must be provided immediately for Medicare members
- Nonurgent, but in-need-of-attention appointments within one week
- Routine and preventive care or well-child appointments within 30 days

In addition Humana recommends the following standards for all physicians:

- Response to urgent calls within 15 minutes; response to routine calls within the same business day
- After hours, response to urgent calls in 15 minutes; non-urgent response in 30 minutes
- Specialty care within 21 business days
- In the case of an unexpected emergency, which may cause this standard to be exceeded, the Member should be promptly notified and given the option of waiting or rescheduling

Note: State regulations, if more stringent, may take precedence over these time frames.

By monitoring compliance with these guidelines over time, Humana can take action to improve Member service availability and access to medical services when necessary. Humana may monitor compliance with the following access standards through a variety of ways including audits during site surveys, telephone audits, and Member surveys and complaints.

HMO Member/Enrollee Transfers: The following guidelines apply to the transfer of a Humana Member upon his/her request from one primary care office to another:

- The Member's decision to transfer should be strictly voluntary.
- The Member or the legal guardian requesting a change in the primary care office may do one of the following:
 - Sign an Enrollment Change Form or a Membership Change Authorization Form.
 - Contact Humana's Customer Service.
 - Call the phone number on the back of the Member ID card to arrange the transfer.
- The Member must not have been directly recruited by telephone or in person by anyone involved with either primary care office.
- The Member must not have been influenced to transfer offices due to improper or incorrect information, or for medical reasons.
- Upon a Member's request, the primary care office must send his/her medical records to the newly selected primary care office

Humana may review the transfer and, if any of the above guidelines have been violated, a transfer in primary care offices will not be approved.

HMO PCP Transfer of Member/Enrollee: If a PCP wants to transfer a Member or his/her power of attorney/guardian to another PCP, the PCP must prepare a Physician Initiated Transfer Request Member Notice and forward it with supporting documentation to the local Humana market medical director, chief executive officer (CEO), president, or market president. The form may be obtained through the local Humana market office. The PCP will be notified of the approval/denial decision. **PCPs may not coerce a Member to transfer.**

Any primary care office that violates guidelines for transferring Members to another office is given a 30-day, noncompliance written notification requiring immediate corrective action. No further written notice is necessary to terminate the Agreement if the primary care office is found in violation of established policies and procedures and is, therefore, considered to be noncompliant. Members or their power of attorneys/guardians have the right to file a grievance if the transfer is approved.

Disenrollment Outside the Service Area: A Member must notify a customer service representative when he/she permanently moves out of the service area. A permanent move is an absence of more than six (6) months.

Medicare Advantage Members: If a Plan offers a continuation area, permanent out-of-area Medicare Advantage Members will receive benefits in the continuation area. The primary care office must:

- a. Obtain documented acceptable evidence indicating the Member has permanently moved out of the service area. Acceptable evidence includes:
 - Certified return receipt letters, indicating an absence of more than six months.
 - Conversation documented and witnessed when a Member admits to a permanent absence from the service area, but does not voluntarily choose to disenroll.
 - Medical records, which indicate an absence of more than six months from the service area.
- b. Complete a Request to Disenroll form (available from the local Humana market office or by calling provider relations at 1-800-626-2741) and attach any supporting documentation regarding the Member's move outside the service area.
- c. Send the form and documentation to the following address:

Humana

Attention: Out of Service Area
Medicare Enrollment Department
P.O. Box 14168
Lexington, KY 40512

Medicare enrollment reviews the request and supporting documentation. If there is sufficient evidence indicating the Member has left the service area, the documentation is submitted to CMS. A letter is sent to the Member from the Medicare retention unit to advise him/her of the effective disenrollment date and to give the Member an opportunity to request a reconsideration if he/she disagrees with the decision. If the Member does not respond within six (6) months from the date of the letter, Member will be disenrolled.

If Medicare enrollment does not agree with the primary care office's request for disenrollment, the office may be asked to gather additional information in support of its case and resubmit the request.

Preferred Provider Organization (PPO)

Under a commercial PPO Plan, Members may use the Provider of their choice, regardless of whether the Provider participates in the PPO network. However, when participating Providers are used, Members have a higher level of coverage.

Medicare Advantage PPO Plans require that Members use a Medicare Provider, except in emergent/urgent situations. Some Medicare Advantage PPO Plans require or request Members to name a primary physician. This PCP name may display on Member ID cards.

X. Credentialing

Credentialing refers to a process performed by Humana to verify and confirm that an applicant (physician and/or other provider type) meets the established policy standards and qualifications for consideration in a Humana provider network. Upon completion of the credentialing process, each applicant is presented to the Credentials Committee which is comprised of physicians in various specialties for review and recommendation. Initial credentialing is performed when an application is received and recredentialing is conducted at least every three (3) years thereafter or as otherwise required by state regulations and at the discretion of the health Plan.

There is required supporting documentation that must be submitted with each credentialing application. Such documentation may include, but is not limited to, licensure, education, training, clinical privileges, work history, accreditation, certifications, professional liability insurance, malpractice history, professional competency, and any physical or mental impairments. Documentation submitted by an applicant and/or Provider's office is verified for accuracy and completeness. At the discretion of Humana an applicant may be required to submit additional information.

Humana recognizes a Provider's right to review information submitted in support of his/her credentialing application to the extent permitted by law and to correct erroneous information. At any time during the credentialing process a Provider may request the status of his/her application by contacting the Humana Credentialing Department. The fact that a Provider is credentialed is not intended as a guarantee or promise of any particular level of care or service.

Council for Affordable Quality Healthcare: Humana is a member of the Council for Affordable Quality Healthcare ("CAQH"). CAQH is an online single entry national database that eliminates the need for Providers to complete and submit multiple credentialing applications. Physicians and other health care Providers who are members of CAQH are able to submit an initial credentialing application to Humana or provide the required information at recredentialing rather than completing credentialing applications. Additional information is available by contacting the Humana Credentialing Department. Please note the aforementioned information is relative to participating Providers only. Nonparticipating providers interested in joining our network should use our online contracting form (<http://www.humana.com/providers/network/>).

Humana Credentials Committee: The Humana credentials committee is composed of a chairperson and Humana's employed and participating Providers. Functions of the committee include credentialing, ongoing and periodic assessment of current policies/procedures, recredentialing, and the establishment of policies and procedures based on current guidelines and regulations.

Providers seeking network participation or recredentialing are presented to the Humana Credentials Committee for review and a recommendation. The committee will render a recommendation to approve or deny network participation. The provider will be notified of the committee's decision. If approved, an Agreement is executed by the provider and Humana.

Recredentialing: The process of recredentialing is conducted at least every three years in accordance with Humana's Recredentialing Policy or as otherwise required by state regulations and at the discretion of the health Plan.

Termination without Cause: As required by law, Humana shall notify a Provider in advance of terminating his/her Agreement. The notification time frames are defined in the Agreement and/or applicable state and federal regulations. Humana has the right to terminate any individual Provider or Provider location, or line of business within the time frames specified in the termination process of the Agreement, unless otherwise stated by state or federal law.

Individual Providers participating in Humana's Medicare Advantage network, whose Agreements are terminated by Humana, may be entitled to a physician panel review. Also, depending on the state and/or designation of Humana's accreditation by the Utilization Review Accreditation Committee ("URAC"), an appeal or advisory panel review of the termination may be available for certain products.

Should a Provider, IPA, or PHO elect to terminate network participation, a notice of the pending termination must be forwarded to Humana in accordance to the terms of the Agreement and applicable state and federal regulations.

Note 1: Humana has an established policy and procedures to notify Members in advance of an impending termination of any Provider. Advance notice is required by Humana in order to comply with all federal and state laws, rules and regulations, as well as accreditation agencies, regarding the notification to all Members affected by the termination of a Provider.

Note 2: Humana reviews the Department of Health and Human Services' ("HHS") and the OIG's exclusion lists as often as required by federal regulations. Should a Provider's name appear on a current OIG excluded provider listing, Humana will take immediate action to terminate the Provider's network participation and, if applicable, take appropriate corrective actions. No hearing is allowed. Other sanctions (e.g., loss of professional license) are also grounds for immediate termination.

XI. Quality/Disease Management

Quality Management

Upon request, Humana will make available to Providers information about its quality management and quality improvement program and a summary report on Humana's progress in meeting quality improvement goals including a description of the quality improvement program and a report on the organization's progress in meeting its goals. To obtain a copy, call the local Humana market office's Quality Management Department or call provider relations at 1-800-626-2741. Access to the Humana Quality Program is also available on the Provider website.

Quality Management Activities: Participating Providers agree to allow and assist Humana with its performance of the following quality management activities:

- **Medical Records Reviews** - Conducted to meet requirements of accrediting agencies and federal and state law requirements. Annually, Humana may review a sample of clinical records for Humana Members. Humana does not review all records and is not responsible for assuring the adequacy or completeness of records.
- **HEDIS®** - Healthcare Effectiveness Data and Information Set ("HEDIS") is a set of performance measures. Humana may conduct Medical Record Reviews to identify gaps in care for Humana Members.

- **CAHPS®** – The Consumer Assessment of Healthcare Providers and Systems (“CAHPS”) survey includes several measures that reflect Member satisfaction with the care and service provided by the physician.
- **HOS** – The Health Outcomes Survey (“HOS”) includes several measures that reflect Member’s self-reported health perception, Member’s discussion with practitioner, and Member’s report of receiving treatment from practitioner. Health plans use the data from HOS for quality improvement activities. CMS also uses this report to judge health plan’s ability to maintain or improve physical and mental health of its Members, provide health plan accountability, and publicly report outcomes.
- Humana is rated by the government on multiple measures that fall under HEDIS, CAHPS and HOS on an annual basis. Each year surveys are sent out to our Members that ask multiple questions of how you the physician and Humana are performing. The results of these surveys dictate how much Humana will get reimbursed by the government. So, it is imperative that we partner to strive for excellence in these areas. For further information please visit www.cms.gov.
- **Occurrences and Adverse Events Reporting** – Unexpected occurrences and adverse events involving Members are reported to the Quality Management Department by Providers, precertification nurses and case managers. Cases are reviewed according to Humana’s Quality Management, and as applicable, Peer Review process as required by law and accrediting agencies.
- **CMS Quality Improvement Organization (“QIO”)** – QIO oversees the Medicare Advantage Prescription Drug (“MAPD”) Plans and collaborates with the Plan for Quality Improvement activities.
- **Member Complaints** – Member complaints and grievances pertaining to a quality-of-care and concerns may be referred to the Quality Management Department for review.
- **Medicare Advantage (“MA”) Organizations must comply with the following requirements:**
 - Maintain a health information system that collects, integrates, analyzes and reports data necessary to implement the quality improvement program.
 - Have a Chronic Care Improvement Program (“CCIP”) that identifies enrollees with multiple or severe chronic conditions, who meet the criteria for participation and a mechanism for monitoring enrollee participation in the program.
 - Initiate Quality Improvement projects (“QIP”) that address those areas that have been identified as health care priorities for MA beneficiaries, or topics that are mandated by CMS or other regulatory bodies.

Personal Nurse: Humana’s Personal Nurse® (“PN”) service is a telephonic outreach program that may be available to commercial Members. The PN program is intended to provide Members with information that they can use in discussing their care with their Providers.

Disease Management and Case Management Programs: Humana offers several disease/condition-specific programs designed to provide the Member with education and support. The programs are offered at no cost to Members by Humana and may be offered through approved outside vendors. For MA, the disease management programs are tied to the CCIP.

All approved programs are negotiated by the corporate disease management network area of the Clinical Interventions Department. The department negotiates agreements and performs data analysis. Also, some agreements may be negotiated by an IPA or delegate.

Note: Humana also offers the following clinical programs in an effort to improve Members' health:

Case Management: Humana's case management team works with Members after a hospitalization or procedure, providing discharge support to reduce the risk of readmission. Humana also offers specialized case management support for the following:

- Neonatal Intensive Care Unit admissions
- Transplant
- Bariatric Surgery

Humana's disease management programs may include, but are not limited to:

- Asthma
- Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes
- End Stage Renal Disease (ESRD)
- Specialty Conditions:
 - Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)
 - Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
 - Cystic Fibrosis
 - Dermatomyositis
 - Hemophilia
 - Systemic Lupus Erythematosus (Lupus)
 - Multiple Sclerosis (MS)
 - Myasthenia Gravis
 - Parkinson's Disease
 - Polymyositis
 - Rheumatoid Arthritis
 - Sickle Cell Disease
 - Scleroderma

Note: Availability of these programs varies by Humana markets.

The Disease Management Department identifies Humana Members who may be eligible for the specific disease management programs. Members who are identified by the Provider in the inpatient or outpatient setting as being candidates for any of the disease management programs may contact Humana Customer Service for information on Humana's disease management program. Please note the disease management or case management referral process above.

HumanaBeginnings®: Humana's maternity management program may be available to commercial Members. It offers prenatal education and guidance for expectant Members from the early stages of pregnancy through baby's first months. HumanaBeginnings is available to all expectant eligible Members, postpartum Members, and Members who have had a pregnancy loss.

HumanaFirst®: This nurse triage and health planning service may be available to MA and commercial Members. It is available 24 hours a day, seven days a week. Members can talk to a nurse about any immediate medical concerns or obtain health planning and support.

XII. Rights and Responsibilities

Physicians'/Providers' Rights and Responsibilities

In order to comply with the requirements of accrediting and regulatory agencies, Humana has adopted certain rules for participating Providers (commercial and Medicare) that are summarized below. This is not a comprehensive, all-inclusive list. Additional responsibilities are presented elsewhere in this Manual and the Agreement. Physician/Providers must:

- Have a professional degree and a current, unrestricted license to practice medicine in the state in which Provider's services are regularly performed.
- Be credentialed by Humana and meet all credentialing and recredentialing criteria as required.
- Provide documentation on their experience, background, training, ability, malpractice claims history, disciplinary actions, or sanctions, physical and mental health status for credentialing purposes.
- Possess a current, unrestricted Drug Enforcement Administration ("DEA") certificate, if applicable, and/or a state Controlled Dangerous Substance ("CDS") certificate or license, if applicable.
- Have a current Clinical Laboratory Improvement Amendments ("CLIA") certificate, if applicable.
- Be a medical staff member in good standing with a participating network hospital(s), if he/she makes Plan Member rounds, and have no record of hospital privileges having been reduced, denied or limited; or if so, provide an explanation that is acceptable to the Plan.
- Inform Humana in writing within 24 hours of any revocation or suspension of his/her Bureau of Narcotics and Dangerous Drugs number, and/or of suspension, limitation, or revocation of his/her license, reduction and/or denial of hospital privileges, certification, CLIA certificate, or other legal credential authorizing him/her to practice in any state in which the Provider is licensed.
- **Inform Humana immediately** of changes in licensure status, tax identification numbers, NPI, telephone numbers, addresses, status at participating hospitals, Provider status (additions or deletions from Provider practice), loss or decrease in amounts of liability insurance below the required limits, and any other change which would affect his/her participation status with Humana.
- Not discriminate against Members as a result of their participation as Members, their source of payment, age, race, color, national origin, religion, sex, sexual preference, health status or disability.
- Not discriminate in any manner between Humana Members and non-Humana members.
- Inform Members regarding follow-up care or provide training in self-care as required by CMS.
- Assure the availability of physician services to Members 24 hours a day, 7 days a week (required for HMO PCPs and all MA Providers).
- Arrange for on-call and after-hours coverage by a participating and credentialed Humana physician (required for HMO PCPs and all MA Providers).

- Refer Humana Members with problems outside of their normal scope of practice for consultation and/or care to appropriate specialists contracted with Humana on a timely basis, except when Participating Providers are not reasonably available or in an emergency.
- Refer Members only to participating providers, except when Participating Providers are not reasonably available or in an emergency.
- Admit Members only to participating network hospitals, SNFs, and other facilities, and work with hospital-based physicians at participating hospitals or facilities in cases of need for acute hospital care, except when Participating Provider or facilities are not reasonably available or in an emergency.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Humana Member, subscriber, or enrollee other than for copayments, deductibles, coinsurance, other fees that are the Member's responsibility under the terms of their benefit Plan, or fees for non-Covered Services furnished on a fee-for-service basis. Non-Covered Services are services not covered by Medicare, or services excluded in the Member's Plan.
- Provide services in a culturally competent manner, (i.e., removing all language barriers) as required by state and federal law. Care and services should accommodate the special needs of ethnic, cultural, and social circumstances of the patient. Additional information and resources are made available by the U.S. Department of Health and Human Services, Office of Minority Health (e.g., <http://minorityhealth.hhs.gov> and <https://www.thinkculturalhealth.hhs.gov/>).
- Provide access to health care benefits for all Plan Members, in a manner consistent with CMS requirements for any Humana Medicare Advantage Members.
- For Medicare Advantage Members who have End Stage Renal Disease ("ESRD"), complete Chronic Renal Disease Medical Evidence Report, which is provided by the Social Security Office when Provider becomes aware of the disease. The form must be completed and returned to the Social Security Office and the ESRD Network. Mail or fax the form to the following address:

Humana

Attn: Medicare Reconciliation Department – ESRD Unit
 Waterside Building
 101 E. Main Street
 Louisville, KY 40202
 FAX: 502-508-3450

- Provide or arrange for continued treatment to all Members, including but not limited, to medication therapy, upon expiration or termination of the Agreement.
- Help guarantee accessibility of services to Members by maintaining a ratio of Members to full-time equivalent ("FTE") physicians as follows:
 - One physician FTE to 2,400 commercial and Medicare Advantage Member equivalents (CMMEs). An MA Member counts as three Member equivalents; a commercial Member counts as one Member equivalent
 - A physician extender (PA or ARNP) counts as .5 physician FTE for MA and commercial Members
 - One physician FTE for 1,500 Medicaid Members
 - A physician extender (PA or ARNP) counts as .33 physician FTE for Medicaid, and may serve no more than 500 Medicaid Members

Note: Full-time equivalents may vary by markets. Contact the local Humana market office or call provider relations at 1-800-626-2741.

- Retain all agreements, books, documents, papers, and medical records related to the provision of services to Members as required by state and federal laws.
- Treat all Member records and information confidentially, and not release such information without the written consent of the Member, except as indicated herein, or as allowed by state and federal law, including HIPAA regulations.
- Transfer copies of medical records for the purpose of continuity of care to other Humana Providers upon request and at no charge to Humana, the Member, or the requesting party, unless otherwise agreed upon.
- Provide copies of, access to and the opportunity for Humana or its designee to examine the Provider's office books, records, and operations of any related organization or entity involving transactions related to health services provided to Members. A related organization or entity is defined as having:
 - Influence, ownership, or control, and
 - Either a financial relationship or a relationship for rendering services to the primary care office. The purpose of this access is to help guarantee compliance with all financial, operational, quality assurance, and peer review obligations, as well as any other provider obligations stated in the Agreement or in this Manual. Failure by any person or entity involved, including the Provider, to comply with any requests for access within ten (10) business days of receipt of notification, will be considered a breach of contract. For records related to Humana MA enrollees, this access right is for the time stipulated in the Agreement or the time period since the last audit, whichever is greater.
- The sponsoring physician will assume full responsibility to the extent of the law when supervising PAs, ARNPs, and individuals other than physicians whose scope of practice should not extend beyond statutory limitations.
- Submit a report of an encounter for each visit when the Member is seen by the Provider, if the Member receives a HEDIS service. Encounters should be submitted electronically or recorded on a CMS-1500 Claim Form, and submitted according to the time frame listed in the Agreement.
- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.
- Agree to cooperate with Humana in its efforts to comply with its MA agreement(s) and/or MA rules and regulations, and assist Humana in complying with corrective action plans necessary for Humana to comply with such rules and regulations.
- Submit complete Member referral information when applicable and in a timely manner to Humana via electronic means or telephone.
- Notify Humana of scheduled surgeries/procedures requiring inpatient hospitalization.
- Notify Humana/ChoiceCare Network of any material change in Provider's performance of delegated functions, if applicable.

- Notify Humana of his/her termination in a timely manner prior to the effective date of termination.
- Maintain full participation status in the Medicare program, and/or not be excluded from participating in the program.
- Cooperate with an independent review organization's activities pertaining to the provision of services for commercial Members, Medicare enrollees in an MA Plan and Medicaid Members. Respond expeditiously to Humana's requests for medical records or any other documents in order to comply with regulatory requirements, and to provide any additional information about a case in which a Member has filed a grievance or appeal.
- Abide by the rules and regulations and all other lawful standards and policies of the Humana Plan(s) with which the Provider is contracted, including Humana's *Principles of Business Ethics Excerpts for Physicians and other Health Care Professionals*.
- Understand and agree that nothing contained in the Agreement or this Manual is intended to interfere with or hinder communications between Providers and Members regarding a Member's medical condition or available treatment options or to dictate medical judgment.
- For those Providers who participate in MA Networks, abide by the guidelines set out in Humana's Rules of Participation for MA Networks, which are available on Humana.com, the Secure Provider Self-Service section, under Resources. A paper copy may be obtained upon request.
- Providers, who have downstream agreement(s) with physicians or other Providers who provide services to Humana Members, agree to provide a copy of said agreement(s) to Humana upon request (financial information will not be requested).
- **Understand and agree that Provider performance data can be used by Humana.**

Members' Rights and Responsibilities

Humana adheres to certain rules of accrediting and regulatory agencies concerning Member rights. Humana Members have certain rights and responsibilities when being treated by Humana-contracted Providers. The rights and responsibilities statement below, though not intended to be exhaustive, reminds Members and Providers of their complimentary roles in maintaining a productive relationship.

Humana Members have the right to:

- Be provided with information about their Humana health Plan, its services and benefits, its Providers, and the rights and responsibilities of Members.
- Choose a primary care physician from our network of affiliated physicians and to change to another primary care physician in the Humana network.
- Discuss their medical record with their physician and receive, upon request, a copy of that record.
- To participate with Providers in making decisions about their health care.

- Have a candid discussion with their Provider about appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Expect reasonable access to medically necessary health care services, regardless of race, national origin, religion, physical abilities, or source payment.
- File a formal complaint, as outlined in the Plan's grievance procedure, and expect a response to that complaint within a reasonable period of time.
- Be treated with courtesy and respect, with appreciation for their dignity, and protection of their right to privacy.
- Make recommendations regarding the Plan's "rights and responsibilities" policies.
- Expect Humana to adhere to all privacy and confidentiality policies and procedures.
- Have an initial health risk assessment conducted for care for MA Members within 90 days of enrollment.
- Have direct access to a woman's health specialist, within the network, for routine and preventive health services, such as mammography screening and influenza vaccinations that are provided as basic benefits for women.
- Have direct access to influenza vaccinations for routine and preventive health services provided as basic benefits. (Certain preventive health services, such as influenza and pneumococcal vaccines, do not require a copayment.)
- Receive services in a culturally competent manner.
- Receive treatment for any emergency medical condition.

Humana Members have the responsibility to:

- Give the Plan and their health care Provider complete and accurate information needed for their care.
- Read and be aware of all material distributed by the Plan explaining policies and procedures regarding services and benefits.
- Obtain and carefully consider all information they may need or desire to give informed consent for a procedure or treatment.
- Be considerate and cooperative in dealing with the Plan Providers and respect the rights of fellow Members.
- Express opinions, concerns or complaints in a constructive manner.
- Tell Humana in writing if they move or change their address or phone number, even if these changes are only temporary.
- Pay all copayments or premiums by the due date.
- Follow health care facility rules and regulations affecting patient care and conduct.
- Carry their Humana identification card with them at all times and use it while enrolled in the Plan.
- Follow the plans and instructions for care that they have agreed upon with their Providers.
- MA Members who have a disagreement with his/her physician about a denial of service have the right to request and receive an organization determination from the Plan regarding the services or treatment being requested.

Note: In some states, Providers are required by law to post Members' rights and responsibilities. To be in compliance with CMS, Humana has a process in place for both current and prospective beneficiaries to exercise choice in obtaining Medicare services.

Advance Directives: The Patient Self-Determination Act of 1990 and state law provides every adult Member the right to make certain decisions concerning medical treatment. Members have the right, under certain conditions, to decide whether to accept or reject medical treatment, including whether to continue medical treatment that would prolong life artificially.

These rights may be communicated by the Member through an Advance Directive. Two kinds of Advance Directives are generally recognized by law: the Living Will and the Durable Power of Attorney for Healthcare.

The Member's primary care office is not required to have Living Will or Durable Power of Attorney blank forms available. However, the primary care office must have procedures in place to help assure that the existence of these forms is conspicuously noted in the Member's medical record.

Professional Conduct During Physical Examination of Plan Members: The Member or Provider may request a chaperone to be present during any office examination. The chaperone may be a family member or friend of the Member, or the physician's/Provider's assistant. Prior to an examination of a minor, the physician should obtain a parent or guardian's consent in the manner specified by the state.

Note: Some states have regulations that may conflict with these guidelines. In those instances, state regulations, if more stringent, take precedence over these guidelines.

XIII. Accreditation

Accreditation requirements vary by state and accreditation organizations. Accrediting agencies generally measure Plan and Provider performance against accreditation standards.

National Committee for Quality Assurance ("NCQA"): The NCQA review process examines the organization's quality improvement program structure, tests quality improvement processes, and looks for evidence that quality improvement activities have resulted in measurable improvement in the organization's performance in both clinical and service areas.

HEDIS® is designed to measure Plan and Provider performance on a number of measures to produce a consumer report card. The information collected from managed care Plans is published to assist consumers in choosing a health care Plan, physicians and other health care Providers. Specific HEDIS measures may change annually to reflect medical advances and to identify new areas in which to focus improvement efforts.

Humana prepares information for NCQA based on data obtained from participating Providers in the form of claims or encounter records. For example, one HEDIS measure is to determine if Members with diabetes receive an annual dilated eye examination. The percent of diabetic Members who meet HEDIS criteria and have an encounter reported for a dilated retinal eye examination is reported. If there is no report of such an examination, the Member is identified as needing an examination. An annual reminder may be generated to Members who have not met the HEDIS criteria for certain measures.

Periodically, the health Plan Quality Management Department may visit Provider offices to review medical records of Members and to collect data.

URAC (originally known as Utilization Review Accreditation Commission): A nonprofit organization founded in 1990 to establish standards for the health care industry by providing a method of evaluation and accreditation of organizations such as health plans and preferred provider organizations. Also known as the American Accreditation Healthcare Commission, URAC accredits many types of health care organizations. There are over 25 different accreditation and certification programs, some that review the entire organization, such as the health plan standards, and some that focus on a single functional area in an organization, e.g., case management or credentialing. Any organization that meets the standards, including hospitals, HMOs, PPOs, TPAs, and Provider groups can seek accreditation.

XIV. Delegation

Delegation is a formal process by which a health plan provides a Provider group with the authority to perform certain functions on its behalf, such as credentialing, utilization management, and claims payment. A function may be fully or partially delegated.

Full delegation allows all activities of a function to be delegated. Partial delegation allows some of the activities to be delegated. The decision of what function may be considered for delegation is determined by the type of Agreement a Provider group has with Humana, as well as the ability of the Provider group to perform the function. Contact the local Humana market office Provider representative for detailed information on delegation, or call provider relations at 1-800-626-2741. Note: Although Humana can delegate the authority to perform a function, it cannot delegate the ultimate responsibility for fulfilling the service or obligation.

Delegated Providers must comply with the responsibilities outlined in the Delegated Services, Policies and Procedures, Appendix A, of this Manual. The document is available on Humana.com, or a copy may also be obtained from the local Humana market office, or by calling 1-800-626-2741.

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I. Introduction

Health Value Management, Inc. d/b/a ChoiceCare Network is a wholly owned subsidiary of Humana, Inc. and one of the largest health care provider networks in the United States, offering access to more than 500,000 providers and 2,700 hospitals from coast to coast. Humana, Inc. is one of the nation's largest publicly traded health benefits companies with:

- more than 40 years of experience
- more than 6.7 million health Plan Members
- over \$12 billion in revenue
- A.M. Best ratings in the “very good” to “excellent” categories for its health Plans

More than 1.4 million Humana Members access ChoiceCare Network Providers nationwide.

Purpose

This section is an extension of the Agreement and furnishes the Provider and the Provider's staff with information concerning ChoiceCare Network policies and procedures, claims and guidelines.

To comply with the Policies and Procedures clause of the participation Agreement, please obtain a Provider Manual for each ChoiceCare Network Payor to determine which policies and procedures are applicable to each Payor.

To comply with the Policies and Procedures clause of the Agreement where Humana is the Payor, a Provider must abide by all provisions contained in Chapter One as well as Chapter Two and any other applicable sections of the Manual.

Questions or Comments


Questions or comments about the policies and procedures in this Manual should be directed to the ChoiceCare Network Provider Relations department at the address or phone number listed below:

ChoiceCare Network
Provider Relations Department
P.O. Box 19013
Green Bay, WI 54307
Telephone Number: 1-800-626-2741
Fax Number: 1-800-626-1686
Email: chcpr@humana.com

II. Claims Procedures

ChoiceCare Network Identification Cards

All patients should have an ID card. Key information is identified on the sample identification card below:

Payor MEMBER ID 9999999999 MEMBER NAME Last Name First Name MEDICAL COVERAGE  COPAYMENT		PPO GROUP NUMBER 77777777 EFFECTIVE DATE MM/DD/YY PPO NETWORK <u>OFFICE COPAYMENT</u> \$xx.xx <u>EMERGENCY ROOM</u> \$xx.xx		Present this card to your provider at the time services are rendered. Precertification is required, please call 1-xxx-xxx-xxxx For more information, refer to your Certificate of Coverage Benefit and Claims Information: 1-xxx-xxx-xxxx Enrollment Changes: Contact your local HR representative Provider Verification: to verify if your doctor, hospital, or facility is in the ChoiceCare Network: Call 1-xxx-xxx-xxxx This plan provides automatic assignment of benefits to the provider. Mail itemized bills, including diagnosis to the Plan Supervisor at: Attn: Claims Department Payor's Name Payor's Claims Department Address Payor's Claims Department City, State, Zip Code Payor's Offering Statement
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Verification of Member Benefits and Eligibility

The Member ID card bears the name and logo of the insurance company or Plan administrator to contact to verify Member benefits and eligibility. The verification phone number and/or Website address can also be found on the Member ID card.

The ChoiceCare Network is a provider network, not an insurance company, health plan administrator or other Payor and, therefore, does not provide verification of Member eligibility and benefits.

Preauthorization and Notification

Preadmission review and authorization may be required by the Payor. If Humana is the Payor, refer to Chapter One of this Manual (Preauthorization and Notification).

Please refer to the Member's ID card for instructions and the appropriate phone number to call. The following information will be required:

- Subscriber's name
- Patient's name, ID number, date of birth and address
- Patient's relationship to subscriber
- Group number
- Date and time of planned admission
- Admitting hospital name
- Admitting physician's name
- Applicable ICD-9 codes
- Applicable CPT® and/or HCPCS codes
- Proposed plan of care (including relevant prior therapies)

Claims Submission and Processing

ChoiceCare Network strongly recommends that all claims not requiring paper attachments be submitted via electronic means. Internet-based claims submission is available at no charge to the Provider for Humana Member claims. For Humana claims submitted electronically, contact the Humana Provider deployment team for information at 1-800-4HUMANA (1-800-448-6262).

Provider must submit all claims to Payor or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") compliant 837 electronic format, or a CMS-1500 and/or UB-05, or their successors, within ninety (90) days from the date of service or within the time specified by applicable state law. Payor may, in its sole discretion, deny payment for any claim(s) received by Payor after the later of 180 days from the date of service, or the time specified by applicable state law.

Provider acknowledges and agrees that at no time shall Members be responsible for any payments to Provider except for applicable copayments and non-covered services provided to such Members.

An Explanation of Benefits (EOB) statement for the Member will accompany all payments made by Payors to Providers. If a claim is pended for review, a letter communicating such will be sent to the Provider.

If services are not authorized by the Member's Payor, claims may be pended. Payors' medical management may require either a telephone call, electronic submission of required information or written documentation from the Provider.

Requests for Review of Denied Claims

Providers may request a review of service or claims payment denial by a Payor. To obtain a review, please send a written request to the applicable Payor.

III. Provider Relations

Network Provider Relations representatives assist Providers in understanding ChoiceCare Network's policies and procedures, and coordinate communications between the Provider and the Member's Payor as needed.

Please contact Provider Relations (Telephone: 1-800-626-2741; Fax: 1-800-626-1686; 8 a.m. to 5 p.m. CST) for assistance to:

- Provide information and/or referral to ChoiceCare Network's National Transplant Network
- Provide agreement updates
- Obtain a copy of provider ChoiceCare Network Agreement
- Verify fee schedule information
- Verify credentialing/recredentialing status

Report Changes in Address or Other Practice Information

All changes to the network must be submitted electronically via Humana.com (in the secure Provider portal, "Manage My Demographics") or documented and communicated through the Provider Relations Department. Notices of any changes must adhere to the time frames in the Agreement.

If the Provider's Agreement with ChoiceCare Network is not through a direct provider participation agreement, but rather through an Agreement between ChoiceCare Network and an independent practice association (IPA), physician hospital organization (PHO) or Provider medical group, these changes are to be communicated to ChoiceCare Network by such entity rather than the Provider.

Changes that require notice to ChoiceCare Network may include, but are not limited to, the following:

- Changes in tax identification number (requires a copy of Provider's W-9 form)
- National Provider Indicator (NPI)
- Medicare Number
- Change in billing or service address, telephone numbers or fax numbers
- Office email address

- Name change
- Loss of or change of professional liability insurance
- Addition or deletion of a physician or other Provider in a Provider group
- Change in licensure
- Planned mergers and acquisitions
- Any other change that may affect a Provider's status as a participant in the ChoiceCare Network

Please submit changes at least thirty (30) days prior to the effective date of the change to ChoiceCare Network Provider Relations.

IV. Credentialing

ChoiceCare Network Providers shall be credentialed and recredentialed through Humana, if applicable. For Humana's credentialing process, refer to Chapter One, Section X of this Manual.

V. Rights and Responsibilities

Physician/Provider Rights and Responsibilities

Refer to Chapter One, Section XII of this Manual.

Payors' Members' Rights and Responsibilities

Payors' Members have the right to:

- Be provided with information about their health Plan, its services and benefits, its Providers, and the rights and responsibilities of Members.
- Privacy and confidentiality regarding their medical care and records.
- Discuss their medical record with their physician and receive, upon request, a copy of that record.
- To participate with Providers in making decisions about their health care.
- Have a candid discussion with their provider about appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Expect reasonable access to medically necessary health care services, regardless of race, national origin, religion, physical abilities, or source payment.
- File a formal complaint, as outlined in the Plan's grievance procedure, and expect a response to that complaint within a reasonable period of time.
- Be treated with courtesy and respect, with appreciation for their dignity and protection of their right to privacy.

- Make recommendations regarding the Plan’s “rights and responsibilities” policies.
- Expect Payor to adhere to all privacy and confidentiality policies and procedures
- Have an initial health risk assessment conducted for MA Members within 90 days of enrollment.
- Have direct access to a woman’s health specialist, within the network, for routine and preventive health services, such as mammography screening and influenza vaccinations that are provided as basic benefits for women.
- Have direct access to influenza vaccinations for routine and preventive health services provided as basic benefits. (Certain preventive health services such as influenza and pneumococcal vaccines do not require a copayment.)
- Receive services in a culturally competent manner.
- Receive treatment for any emergency medical condition.

Payors’ Members have the responsibility to:

- Give the Plan and their health care Provider complete and accurate information needed for their care.
- Read and be aware of all material distributed by the Plan explaining policies and procedures regarding services and benefits.
- Obtain and carefully consider all information they may need or desire to give informed consent for a procedure or treatment.
- Be considerate and cooperative in dealing with the Providers and respect the rights of fellow plan Members.
- Express opinions, concerns, or complaints in a constructive manner.
- Notify the Plan in writing if they move or change their address or phone number, even if these changes are only temporary.
- Pay all copayments or premiums by the due date.
- Follow health care facility rules and regulations affecting patient care and conduct.
- Carry their Plan identification card with them at all times and use it while enrolled in the Plan.
- Follow the Plans and instructions for care that they have agreed upon with their Providers.

Note: In some states, Providers are required by law to post Members’ rights and responsibilities.

V. Delegation

Refer to Chapter One, Section XIV of this Manual.

Chapter Three

If required, state specific provisions will be included in this section for the applicable state.

Texas Specific Provisions

A. Clinical Practice Guidelines

Rather than issuing internally developed guidelines for such conditions as congestive heart failure and diabetes, Humana employs nationally recognized guidelines, thus reducing the number of guidelines Providers are encouraged to follow. Humana employs those clinical practice guidelines as required by regulatory and accrediting bodies. These guidelines can be accessed through links on the Provider section of Humana.com. As organizations such as the American Diabetes Association® and the American College of Cardiology update their guidelines, physicians/Providers will have immediate access to the new clinical practice guidelines.

Following are the links to the websites containing the clinical practice guidelines:

- Asthma Care - <http://www.nhlbi.nih.gov/guidelines/asthma/index.htm>
- Childhood Immunizations - http://www.cispimmunize.org/pro/2002_main.html
- Coronary Artery Disease - http://www.acc.org/clinical/guidelines/atherosclerosis/atherosclerosis_pdf
- Diabetes Care - http://care.diabetesjournals.org/cgi/content/full/25/suppl_1/s33
- Heart Failure - http://www.acc.org/clinical/guidelines/failure/hf_index.htm
- Pediatric Preventive Care - <http://www.aap.org/policy/re9939.html>
- Preventive Care - <http://www.ahcpr.gov/clinic/ppiphand.htm>

The following conditions also have links listed under Clinical Practice Guidelines at **Humana.com**:

- Atherosclerotic Cardiovascular Disease
- COPD
- Hypertension
- Kidney Disease
- Medical Records Guidelines
- Obesity Screening

Preventive Services: in compliance with 28 TAC Section 11.1607(g)(3), preventative services must be available to children within 2 months and within 3 months for adults; preventative dental care must be available within 4 months.

B. Requesting Disclosure Information

Pursuant to the Texas Administrative Code 28 TAC 3.3703 and 11.0901, when Humana receives a request from a Provider for disclosure information, Humana will send the information within 30 days of the receipt of the request. Disclosure information, as relevant to a Provider's practice, includes:

- Fee schedules
- Claims processing policies

For each request, use the name of the legal entity with which Provider is contracted, such as Humana Insurance Company (PPO), Humana Health Plan of Texas (HMO) and ChoiceCare® Network (PPO). If Provider has multi-network contracts, please contact the market office responsible for each network.

Requests for this information must be directed to Humana in writing to the Contracting Department/ Network Development by parcel post, email, or facsimile. If the request is not sent to the appropriate address listed below for Provider market/network, the request may not be answered.

C. Referrals

For Texas Providers and for Plans that require referrals, this section replaces and supersedes the referral timelines in Chapter One of this Manual, so as to comply with Texas state law and/or regulations. The PCP initiates the referral by submitting a referral request to Humana via **Humana.com**, Availity.com, telephone or facsimile using the Humana Referral Request form. All HMO Humana Members must be advised by the PCP's office that specialty service appointments will be coordinated within the time frames below:

- **Routine and follow-up appointments** – within 3 weeks for medical conditions; within 8 weeks for dental conditions; and, within 2 weeks for behavioral health conditions
- **Urgent** appointments – within 24 hours
- **Emergent** appointments – immediately

The postal addresses for submission of written requests are:

Austin

Humana – Contracting Department/Network Development
Attention: Provider Relations Department
1221 S. MoPac, Suite 300
Austin, Texas 78746-6875
Fax: 512-338-2565

Corpus Christi

Contracting Department/Network Development
802 N. Carancahua, Suite 1700
Corpus Christi, Texas 78401-0032
Fax: 210-617-1850

Dallas/Ft. Worth

Operations Department
P.O. Box 19013
Green Bay, WI 54307
Fax: 800-626-1686

Houston

Humana
Attn: Contracting Department/Network Development
19009 Greenway Plaza #2000
Houston, Texas 77080
Fax: 713-622-6649

San Antonio

Contracting Department/Network Development
8431 Fredericksburg Road, Suite 580
San Antonio, Texas 78229
Fax: 210-617-1028

Centralized Provider Relations

Operations Department
P.O. Box 19013
Green Bay, WI 54307
Fax: 800-626-1686

D. Designation as a Nontraditional Primary Care Physician (Specialist)

Members with chronic, disabling or life threatening conditions may request a specialist (non-traditional primary care physician) as their PCP. The application will be reviewed by the local health plan medical director and the following factors will be considered:

- Severity of the Member's diagnosis.
- Likelihood of the chronic nature of the Member's condition.
- Likelihood the Member should require frequent and ongoing referral to a specialist other than the traditional PCP.
- Reasonableness of the proposed specialist's field for ongoing care of the Member as PCP.

Note: Decisions regarding the assignment of a nontraditional primary care physician (specialist) are not made with retroactive effective dates. The amount of compensation owed to the original PCP prior to the date of the new designation is not reduced.

Specialist Responsibilities: Any physician serving in the role of a nontraditional PCP is obligated to provide all primary care services as outlined below.

- Specialist is responsible twenty-four (24) hours a day, seven (7) days a week for providing or arranging for all covered services for enrollees, including but not limited to prescribing, directing and authorizing all urgent and emergency care for enrollees.
- Specialist is expected to provide to Humana upon request a written description of his/her arrangements for emergency and urgent care and service coverage in the event of his/her unavailability due to vacation, illness, or after hours. Specialist should make sure that all physicians providing coverage are contracted and credentialed physicians with Humana. Specialist should make sure that all physicians providing coverage render services under the same terms and conditions and in compliance with all provisions of his/her Agreement. Compensation to physicians for "on call" coverage is the responsibility of the specialist.
- In the event that emergency and urgent care services are needed by enrollee outside the service area, the specialist is expected to monitor and authorize the out-of-area care and provide direct care as soon as the enrollee is able to return to the service area for treatment without medically harmful or injurious consequences.
- In the event that the agreement is terminated for whatever reason, specialist is expected to continue enrollee(s)' course of treatment, including but not limited to medication therapy, until the enrollee(s) has been evaluated by a new Provider and the new Provider has had a reasonable opportunity to review or modify enrollee(s)' course of treatment.
- Covered services include but are not limited necessarily to: medical and surgical services, including anesthesia; diagnostic tests and procedures that are a part of treatment; other services ordinarily furnished in the specialist's office, such as X-rays ordered as part of treatment; services of the specialist's office nurse(s); drugs and biologicals that cannot be self-administered; transfusions of blood and blood components and medical supplies.

- Specialist should make sure that the appointment availability standards set forth in Humana's Provider Manual are met. Specialist further agrees that these standards may be changed from time to time by Humana. In the event of such change, Humana agrees to provide specialist with ninety (90) days written notice of such change.
- Specialist is expected to provide primary care services, including but not limited to those outlined below, to enrollees:
 - Routine office visits (including after-hour office visits which can be arranged with other Providers and with Humana's approval) and related services of specialists and other providers rendered in the specialist's office, including evaluation, diagnosis and treatment of illness and injury.
 - Visits and examinations, including consultation time and personal attendance with the Member, during confinement in a hospital, skilled nursing facility or extended care facility.
 - Pediatric and adult immunizations and TB skin testing in accordance with accepted medical practice.
 - Administration of injections, including injectables for which a separate charge is not routinely made.
 - Initial care at birth and well-child care for pediatric enrollees.
 - Periodic health appraisal examinations including all routine tests performed in the specialist's office.
 - Eye and ear screening for children through age seventeen (17) to determine the need for vision or hearing correction.
 - The routine diagnostic laboratory tests under primary care responsibilities including but not limited to: urinalysis, serum glucose, CBC (or any portion thereof), occult blood, gram stains and pregnancy tests.
 - Miscellaneous supplies related to treatment in specialist's office, including gauze, tape, band aids and other routine medical supplies.
 - Member health education services and referrals as appropriate, including informational and personal health patterns, appropriate use of health care services, family planning, adoption and other educational and referral services, but not the cost of such referral services.
 - Telephone consultations with other Providers and Member/enrollee.
- Certain referrals are required to be made to specific Providers designated by Humana. Specialist further acknowledges and agrees that such specific Providers may be changed or added to upon written notice by Humana to Provider.
- Other primary care services as defined normal practice for primary care physicians, including but not limited to all diagnostic laboratory, electrodiagnostic or radiology services ("diagnostic services") provided by specialist.

E. Practice Guidelines

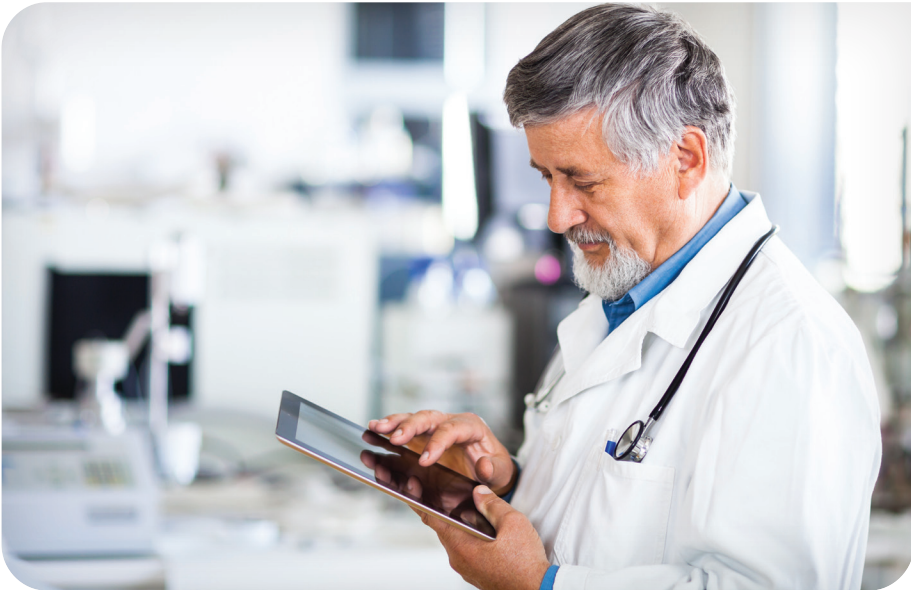
These Clinical Practice Guidelines are developed and approved through a peer-review process with input from community physicians. The guidelines are reviewed at least annually and are updated to reflect changes in standards of care.

Please note that the guidelines are recommendations for care and are not a substitute for a Provider's clinical judgment. Humana is not a provider of medical services and does not control its contracted Providers' clinical judgment or treatment recommendations. The guidelines set forth below are not binding. They may not be applicable in every case. Furthermore, benefit coverage of particular services vary by product and a particular service mentioned in a guideline may not be a covered benefit.

Providers and Members must refer to their certificate of coverage for specific benefit information or call customer service for clarification. The guidelines are also available on Humana.com.

The following guidelines included in this bulletin are:

- Suspected Venous Thromboembolic Disease
- Therapeutic Milestones in the Management of Acute Myocardial Infarction
- Diagnosis and Management of Asthma
- Evaluation of Breast Masses
- Management of Community Acquired Pneumonia in Adults
- Management of CHF in Adults with Left Ventricular Dysfunction
- Management of Chronic Obstructive Pulmonary Disease
- Diagnosis and Initial Assessment of Depression in the Primary Care Setting
- Diagnosis and Management of Diabetes Mellitus in Adults
- Diagnosis and Management of Gastroesophageal Reflux Disease (GERD)
- Management of Hyperlipidemia in Adults
- Diagnosis and Management of Hypertension
- Routine Preventive Health Measures for Children and Adolescents
- Guidelines for Stroke Prevention
- Communication of Diagnostic Test Results to Patients
- Acute Low Back Pain in Adults



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