

# Independent Physician Association (IPA) Handbook

California Version

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This administrative handbook highlights key points related to Humana policies and procedures and serves as a set of guidelines for contracted independent physician associations (IPAs) delivering care to Humana Medicare Advantage members.

We look forward to a long and productive relationship with you and your staff. For further assistance, please contact your Contract Administrator.

## Key Humana Contacts Information

Name	Purpose	Contact Numbers	Hours
Humana Customer Service	General questions, eligibility, benefits and provider information	1-800-457-4708 <a href="http://www.humana-medicare.com">www.humana-medicare.com</a>	Monday through Sunday, 8 a.m. – 8 p.m. EST,
Clinical Intake Team (CIT)	Notification and prior authorization requests	Phone: 1-800-523-0023 Fax: 1-800-266-3022	Phone: Automated assistance seven days a week
CA Health Services Organization (HSO)	CA UM and senior CM assistance	Phone: 1-800-322-2758 option 2, ext. 1500187 Fax: 1-866-559-4783 Email: <a href="mailto:umdeptca@humana.com">umdeptca@humana.com</a>	Monday to Friday, 8 a.m. – 5 p.m. PST
CA HSO Escalated Issues or Questions	Rick Menchaca, R.N. Director, HSO	1-800-322-2758, opt. 2, ext. 1090950 Cell: 562-230-3905 Fax: 1-866-559-4783 Email: <a href="mailto:rmenchaca@humana.com">rmenchaca@humana.com</a>	Monday through Friday, 8 a.m. – 5 p.m. PST
Humana Transplant Team	Transplant information	Phone: 1-866-421-5663 Fax: 502-508-9300 Email: <a href="mailto:transplant@humana.com">transplant@humana.com</a>	Monday through Friday, 8:30 a.m. – 5 p.m. EST
Humana First®	24-hour nurse advise line	1-800-622-9529	24 hours/seven days a week
Humana Language Line	Interpreter/translation services	1-877-228-9235 Client code: 248207	24 hours/seven days a week
Over-the-counter (OTC) Health and Wellness Products	OTC pharmacy (contact customer service for order form)	1-800-457-4708	Monday through Friday, 8 a.m. to 8 p.m. EST
Well Dine	Post-inpatient meal benefit, 10 pack, delivered by UPS/FedEx to home, check benefit first	1-866-96MEALS (1-866-966-3257)	Monday through Friday, 8 a.m. to 9 p.m. EST

## Overview

### About Humana

Humana, headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. By leveraging the strengths of its core businesses, Humana believes it can better explore opportunities for existing and emerging adjacencies in health care that can further enhance wellness opportunities for the millions of people across the nation with whom the company has relationships.

**Questions or comments:** Questions or comments about this handbook should be directed to your Contract Administrator.

## I. Enrollment and Eligibility

### IPA Request to Disenroll a Member from Humana

CMS rarely agrees to disenroll a member for disruptive behavior. IPAs are contractually obligated to continue care for all assigned members. In the event you are unable to resolve an issue with a member, please contact your Humana representative. IPA's are not permitted to refuse care for members who initiate legal action against the IPA or a contract provider. In the event your IPA is notified of legal action, contact your assigned Provider Engagement Consultant.

If you suspect that a member is committing fraud, please contact your assigned Humana provider consultant immediately. For more information, please refer to the "Compliance/Ethics and Fraud, Waste and Abuse" section of this handbook.

**Note:** A member should not be contacted by the IPA or the health care provider regarding involuntary transfer of the member.

### Member Transfers to a Different PCP

Humana members may request transfers to a new primary care physician (PCP) verbally or in writing. Requests should be directed to the Humana member services department. All transfer requests received will be effective on the first day of the following month. Depending on mitigating factors, Humana reserves the right to use the first of the following month for the effective date.

### Hospitalized Member Transfer

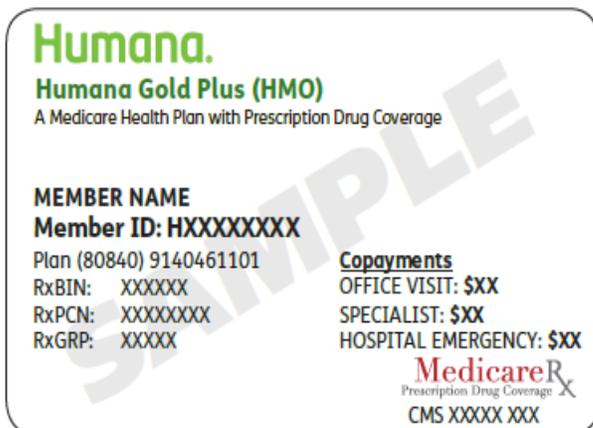
In accordance with Medicare legislation, if a member's disenrollment date occurs during an acute inpatient hospital stay, Humana is required to pay inpatient services through the date of discharge. Beginning January 1, 2004, the Medicare Modernization Act extended this requirement to long-term-care facilities and rehabilitation hospitals or units. As a result, long-term-care facilities and rehabilitation hospitals or units, as well as acute inpatient hospitals, are paid through the date of discharge even though the member's Medicare disenrollment is effective within the date range of his or her stay.

## Coverage Start and End Dates

- **Coverage that begins during an inpatient stay:** If coverage under a new Humana Medicare Advantage (MA) or Medicare Advantage Prescription Drug (MAPD) plan begins while the member is inpatient in a facility described in the Medicare Modernization Act:
  - Payment for inpatient services until the date of the member's discharge is made by the previous plan or Original Medicare, as appropriate.
  - The MA organization offering the newly elected MA/MAPD plan is not responsible for the inpatient services until the date **after** the member's discharge.
- **Coverage that ends during an inpatient stay:** If coverage under a Humana MA/MAPD plan ends while the member is inpatient in a facility described in the Medicare Modernization Act:
  - Humana is responsible for the services until the date of the member's discharge.
  - Payment for those services during the remainder of the stay is not made by Original Medicare or by any succeeding MA organization offering a newly elected MA/MAPD plan.
  - Humana is responsible for the Part B services through the member's disenrollment date.
  - Payment for those services occurring on the effective date of transfer is made by any succeeding MA organization offering a newly elected MA/MAPD plan.

## Medicare Member Card

Sample (front and back):



## II. Member Services

### Transportation

In some counties, where available, members have a benefit for non-emergent transportation services arranged through LogistiCare, Humana's contracted vendor for transportation services. Below are important contact numbers for Humana members:

- Transportation Reservations (members): **1-866-588-5122**
- Ride Assist (members): **1-866-588-5123** (For member assistance when ready for pick up, to schedule trips, make changes or cancel trips)
- Facility (health plan/facility reps): **Phone: 1-866-372-9842, Fax: 1-866-372-9887**
- Hearing impaired (TTY): **1-866-288-3133**

### What types of trips are covered and non-covered?

- **Covered:** Covered transportation is to plan-approved locations for access to medical care or as requested by the member's primary care physician. Examples may include: non-emergent transportation to doctor appointments, outpatient diagnostic and treatment, pharmacy, silver sneakers and counseling.
- **Non-covered:** Examples of non-covered trips may include: emergent transportation of any type, visitation trips, adult daycare, court ordered exams, hospital admissions, AA or other self-help groups.

### Day, weekend and holiday hours of operation for the customer call center:

- Available 8 a.m. to 5 p.m., Monday through Friday
- Closed Saturdays and Sundays and national holidays
- Same-day and urgent requests must be verified by LogistiCare
- LogistiCare will verify member eligibility

### LogistiCare will not:

- Verify a provider's participation status
- Verify closest provider
- Provide meals and lodging
- Deliver prescriptions
- Provide non-medically related transports

### Service area:

- Trips must be within a predetermined service area defined by county. To determine which counties are in the service area, please contact your assigned provider consultant. As long as the member is not required to travel more than 45 minutes longer than if he/she had traveled directly, members may share a vehicle with others.

### Trip mileage limits:

Mileage limits for trips are determined by the member's benefit.

**Out-of-state services:**

Trips for out-of-state services are permitted if the trip is to a contiguous county in another state considered inside a member's normal medical market. Transportation for out-of-state medical appointments that are outside the normal medical market requires a prior authorization from Humana.

**Who can request transportation?**

- Members
- Members' relatives, legal guardians or authorized representatives
- Plan case manager or other plan representative
- Medical facility representatives and medical providers

**Notice requirements:**

The member should call to schedule transportation at least three business days prior to the time of the appointment. The member is required to provide necessary durable medical equipment for transportation, including wheelchairs.

**If the member does not provide three business days' notice to schedule transportation:**

- If it is the member's first time calling, LogistiCare will educate the member, schedule the trip and make a note in its system showing that the member was re-educated on the notice requirement.
- For all future attempts, LogistiCare will re-educate the member and contact the member's facility or doctor to verify the urgency of the appointment. If verified as urgent, LogistiCare will schedule transportation. If the facility or doctor determines the appointment is non-urgent, LogistiCare will document that the member was re-educated on the notice requirement and ask the member to reschedule the appointment to comply with the established amount of notice.

**Note:** Transportation cannot be scheduled more than 10 business days in advance of the appointment.

**"Will call" returns:**

Members can schedule a "will call" return trip when making the reservation and then, when ready, call Ride Assist (1-866-588-5123) to be picked up. Transportation will be provided within one hour from the time of the call.

**Confirming eligibility:**

LogistiCare will collect all of the information for the trip, the member insurance information and a call back number. LogistiCare will call Humana member services at 1-800-457-4708 to verify member eligibility. LogistiCare will not transport a member until eligibility is verified. LogistiCare will call the member to confirm the arrangements.

**Transportation types:**

- Ambulatory: sedan, van, taxi
- Wheelchair lift-equipped vehicle

**Emergency room transportation:**

- Transportation is not allowed to or between emergency rooms.
- Transportation is allowed from emergency rooms.

**Pharmacy trips:**

Trips to the pharmacy are allowed. In the event the trip is associated with a doctor's appointment, the trip leg to the pharmacy will count as one separate trip and the trip leg to take the member to his/her final destination (e.g., home) will count as a separate trip.

**Nursing home transportation:**

- Transportation is allowed from the member's home to a nursing home for admission.
- Transportation is allowed from a nursing home or assisted living facility to a covered service and back to a nursing home or assisted living facility.
- Transportation is allowed from a nursing home to another nursing home for medical necessity.

**Accompanying a member:**

- A member and one additional passenger (e.g., an attendant or escort) are allowed. The attendant/escort must be at least 18 years of age.
- If the attendant/escort is medically necessary to accompany the member to the medical appointment, the transportation will be covered for the attendant/escort.

**Trip limits:**

Numbers of trip limits are determined by the member's benefit. Members must verify trip limits with LogistiCare.

**No copayments:**

If the driver requests a copayment, the member should refuse and indicate that his/her plan benefit does not require a copayment at the time of transport. If there are further questions or the issue is not resolved for the member, the driver should call his/her dispatcher.

**Cultural and Linguistic Services**

To facilitate accurate and effective cross-cultural communication, Humana follows the policies and procedures of its Language Assistance Program (LAP). Humana provides language assistance services for its members with limited proficiency in English. Health care providers may call Humana at the phone number listed on the member's Humana identification card to access interpretation services while the member is in the office.

Humana is committed to providing language assistance services for all members. Spanish versions of Humana's website and member materials, along with free interpretation services for all languages are available. Spanish versions of our Web pages can be accessed by selecting the "Español" link in the upper right corner of Humana's website.

### III. Provider Services

#### Provider Additions, Changes, Terminations and Panel Closures

Humana adheres to established guidelines when evaluating IPA requests to add, change or terminate health care providers to or from the Humana network. Humana relies on IPA's to provide accurate and timely provider data updates. All physician updates should be sent to [Californiaupdates@humana.com](mailto:Californiaupdates@humana.com).

Provider update instructions include, but are not limited to, the following:

- **Profile Data Fields:** All provider profiles are reviewed for credentialing requirements including, but not limited to, those listed in **Attachment A**.
- **PCP profiles:** IPA's may only submit physicians for their assigned service area. The IPA's assigned network specialist can help determine this information.
- **Incomplete requests:** Incomplete requests or requests requiring further attention will be returned to the sender with details regarding the issue(s) found and a request for additional information.
- **Member notification:** Humana will notify members of PCP and hospital changes. IPAs are responsible for identifying and notifying impacted members of specialist changes.
- **Types of PCPs:** Humana considers the following specialty categories as PCPs:
  - Family Practice
  - General Practice
  - Internal Medicine
  - Family Practice: Geriatrics
  - Internal Medicine: Geriatrics

Humana does not consider Obstetricians/Gynecologists (OB/GYNs) or Pediatricians as PCP's for Humana's Medicare products.

IPA will indicate if a Family Practice or Internal Medicine physician has a Geriatrics certificate.

- **PCP phone number:** If the health care provider is a PCP and has more than one practice phone number, the provider must indicate which phone number should be added to the Humana member's identification card.
- **PCP vendor numbers:** Humana assigns a PCP a vendor number (used for enrollment purposes) for each service location a physician practices.

## Humana Provider Website

The Humana provider website provides a variety of applications and reports in one secure and convenient location ([www.humana.com/providers](https://www.humana.com/providers)). Additional references to information on the site can be found in Humana's Provider Manual for physicians, hospitals and health care providers, as well as elsewhere in this handbook.

Humana reserves the right to unilaterally modify all applications and reports on the website, including content and schedule, as long as such modification does not constitute material alteration of the IPA agreement terms.

- **Note:** Additional preauthorization information can be found at:  
<https://www.humana.com/provider/medical-providers/education/claims/pre-authorization>
- Additional delegated provider resources information can be found at:  
<https://www.humana.com/provider/support/delegated-resources/>

#### **IV. Member Grievance/Appeal, Provider Claims Reconsideration and Provider Termination Appeal Processes**

General Information on these topics is covered in Humana's Delegation Provider Manual, posted online at:

<https://www.humana.com/provider/support/publications>

#### **Providers frequently asked questions (FAQ)**

**Provider Claims Reconsideration Process:** refer to page 27 of the Provider Manual for Physicians, Hospitals and Health Care Providers – Delegation found at:

<https://www.humana.com/provider/support/publications>

**Member Grievance & Appeals Process:** refer to page 22 of the Provider Manual for Physicians, Hospitals and Health Care Providers – Delegation found at:

<https://www.humana.com/provider/support/publications>

**For Humana payment disputes:**

<https://www.humana.com/provider/support/claims/financial-recovery/dispute-policy>

## V. Pharmacy

### Pharmacy Quick Reference Guide

Humana Prescribing Information for Health Care Providers											
<b>Humana Provider Website</b>	<a href="https://www.humana.com/providers">Humana.com/providers</a>										
<b>Prescription Tools Online</b>	<p><a href="https://www.humana.com/provider/medical-providers/pharmacy/">https://www.humana.com/provider/medical-providers/pharmacy/</a> (For drug-specific requirements, use the Drug List Search tool on the following page: <a href="https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/drug-list">https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/drug-list</a>)</p>										
<b>e-Prescribing</b>	<p>E-prescribing Information: <a href="https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/electronic-prescribing">https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/electronic-prescribing</a></p>										
<b>Medical and Rx Coverage Policies</b>	<a href="http://apps.humana.com/tad/tad_new/home.aspx?type=provider">http://apps.humana.com/tad/tad_new/home.aspx?type=provider</a>										
<b>Humana Clinical Pharmacy Review</b>	For medication supplied by a pharmacy and billed through the pharmacy benefit										
<ul style="list-style-type: none"> <li>- Medication Prior Authorization (PA)</li> <li>- Fax Form Requirements</li> <li>- Contact Information for Questions</li> </ul>	<table border="1"> <tr> <td>Medication Prior Authorization Process</td> <td>           Obtain forms online:  <a href="https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/prior-authorization">https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/prior-authorization</a>            Submit request by fax: 1-877-486-2621            View Humana drug lists:  <a href="https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/drug-list">https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/drug-list</a> </td> </tr> <tr> <td>Requirements for Fax Form</td> <td> <ul style="list-style-type: none"> <li>• Tax identification number of prescriber</li> <li>• Member address</li> <li>• Prescriber address</li> <li>• Time period and outcome of past therapy tried/failed</li> </ul> </td> </tr> <tr> <td>Generic Guide</td> <td>           Find a generic drug guide:  <a href="https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/generic-drugs">https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/generic-drugs</a> </td> </tr> <tr> <td>Provider Questions</td> <td>1-800-555-CLIN (1-800-555-2546); Monday – Friday, 8 a.m. to midnight EST</td> </tr> <tr> <td>Member Questions</td> <td>Medicare: 1-800-457-4708</td> </tr> </table>	Medication Prior Authorization Process	Obtain forms online: <a href="https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/prior-authorization">https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/prior-authorization</a> Submit request by fax: 1-877-486-2621 View Humana drug lists: <a href="https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/drug-list">https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/drug-list</a>	Requirements for Fax Form	<ul style="list-style-type: none"> <li>• Tax identification number of prescriber</li> <li>• Member address</li> <li>• Prescriber address</li> <li>• Time period and outcome of past therapy tried/failed</li> </ul>	Generic Guide	Find a generic drug guide: <a href="https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/generic-drugs">https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/generic-drugs</a>	Provider Questions	1-800-555-CLIN (1-800-555-2546); Monday – Friday, 8 a.m. to midnight EST	Member Questions	Medicare: 1-800-457-4708
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Provider Questions	1-800-555-CLIN (1-800-555-2546); Monday – Friday, 8 a.m. to midnight EST										
Member Questions	Medicare: 1-800-457-4708										
<b>Other Humana Contact Information</b>											
<b>Humana Clinical Pharmacy Review</b>	1-800-555-CLIN (1-800-555-2546) (Fax: 1-877-486-2621); Monday – Friday, 8 a.m. to 12 midnight EST										
<b>Humana Pharmacy</b> (Prescription Home Delivery)	1-800-379-0092 (Fax: 1-800-379-7617), Monday – Friday, 8 a.m. to 11 p.m. EST; Saturday, 8 a.m. to 6:30 p.m. EST <a href="https://www.humanapharmacy.com/">https://www.humanapharmacy.com/</a>										
<b>Humana Pharmacy Specialty</b>	1-800-486-2668 (Fax: 1-877-405-7940), Monday – Friday, 8 a.m. to 8 p.m. EST; <a href="https://www.humanapharmacy.com/Specialty/page/HP-SpecialtyMeds.cmd?cm_sp=Humanapharmacy.com- -Humana_Specialty_Pharmacy_Promo-">https://www.humanapharmacy.com/Specialty/page/HP-SpecialtyMeds.cmd?cm_sp=Humanapharmacy.com- -Humana_Specialty_Pharmacy_Promo-</a>										



## VI. Utilization Management

### Utilization Management (UM) Functions

The California Health Services Organization (HSO) provides assistance to Humana's health care provider network. IPA UM staff may contact HSO by the following options:

- Email: [umdeptca@humana.com](mailto:umdeptca@humana.com),
- Phone: 1-800-322-2758, option 2, extension 1500187
- Fax: 1-866-559-4783

We've included lists of important Humana UM and case management (CM) contacts for IPAs in this handbook (see page 4).

New IPAs must review the information related to IPA contacts for Humana, complete the form on page 22 with their IPA contacts and submit it to Humana HSO as instructed.

**Authorization process – delegated IPA:** The delegated IPA should perform the basic elements of the referral management process, including, but not limited to, eligibility and benefit coverage verification and medical necessity review. The IPA's processes for referral management must include, but are not limited to, those listed on the Delegation Services Addendum and related attachments ("Delegation Services Addendum") in the Independent Practice Association Participation Agreement.

**Authorization log reporting requirements to CA HSO:** When an IPA is delegated for UM functions, financial responsibility may be shared. For services that Humana is financially responsible to pay, an authorization must be present in the Humana clinical system. For this reason, Humana requires the IPA to submit weekly authorization logs, approved and denied, to the CA HSO department. UM associates create Humana authorizations for the services listed on the IPA's authorization log that are to be paid or denied according to the IPA's authorization review decisions. Refer to "Humana Requirement for IPA Authorization/Denial file submission" in Attachment B.

**Out-of-area hospitalizations:** Out-of-area (OOA) services are covered for urgent or emergent care only. Coverage for OOA services is defined in each Independent Practice Association Participation Agreement. OOA services that are not urgent or emergent must be reviewed on a pre-service basis and approved by the delegated IPA's UM department.

When the Independent Practice Association Participation Agreement denotes Humana as fully responsible for professional and facility components, the Humana OOA clinical advisor, senior case manager (SCM) and medical director will conduct UM functions with the attending health care provider.

The management of OOA hospitalizations is a collaborative effort between the Humana clinical advisor and SCM and the delegated IPA's UM department. The delegated IPA and the member's PCP are expected to respond in a timely fashion to Humana's requests for assistance with transferring member's in-network.

**Case management:** Delegated IPAs are responsible for developing a CM program. Case management is a delegated function performed by the IPA's case managers. Members may be identified for case management through various sources including, but not limited to, UM staff, physicians, family members, claims data, utilization management reports, pharmacy data, etc. Humana HSO associates monitor daily reports to identify members who may benefit from case management. Members identified on reports for possible case management are referred to their IPA case management contacts for CM screening.

**Letters of agreement for nonparticipating providers:** If the IPA authorizes it, the nonparticipating health care provider may agree to provide services and see a member with IPA authorization alone; no letter of agreement (LOA) is required and Humana will pay at 100 percent Medicare rates.

An LOA from Humana is required when:

1. There is an approved IPA authorization.
2. The facility wants more than 100 percent of Medicare rates.
3. Humana is financially responsible for payment to the health care provider.
4. The nonparticipating health care provider does not accept the IPA's authorization alone and requires a LOA.

**Humana clinical programs:** If the Delegation Services Addendum includes access to the Humana clinical programs listed below, the IPA may refer members to these Humana programs. The Delegation Services Addendum is referred to as an attachment or table in the Independent Practice Association Participation Agreement. These clinical programs are listed in the Delegation Services Addendum as:

- Transplant services UM/utilization review (UR) and CM

**Transplant services:** Transplant management is a specialty case management program staffed with transplant-experienced clinical advisors who provide benefit guidance, suggestions of National Transplant Network (NTN) facilities and education to members having solid organ or bone marrow transplants.

Members supported by the transplant clinical team face overwhelming physical, emotional and financial challenges. Transplant clinical advisors help members maximize their benefits, as well as locate an NTN facility that can best meet the member's needs. The clinical advisor serves as a single point of contact for health care providers throughout the pre- and post-transplant process. To contact transplant management, call 1-866-421-5663, fax 502-508-9300 or email [transplant@humana.com](mailto:transplant@humana.com).

## CMS-approved denial notice templates

**Note:** All denial notice templates are provided to the IPA by Humana's delegation department.

- **Notice of Denial of Medical Coverage (NDMC)** should be drafted and issued for pre-service standard and expedited authorization requests, exhaustion of skilled nursing benefits, pre-service denial for skilled nursing admission, psychiatric facility exhaustion of benefits and refusal to transfer.
- The CMS-required **Important Message from Medicare about Your Rights** should be drafted and issued by 12 p.m. the following business day for acute hospitals after Quality Improvement Organization (QIO) notification (only if the member has filed an appeal with the QIO to dispute hospital discharge).
- **Detailed Notice of Discharge (DND)** should be drafted and issued only if the member has filed an appeal with the QIO to dispute hospital discharge.
- **Notice of Medicare Non-Coverage (NOMNC)** should be drafted and issued on all terminations of service by a skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF). It must be delivered to the member in two calendar days. An acknowledgement of receipt is required.
- **Detailed Explanation of Non-Coverage (DENC)** must be issued when a member has filed an appeal with the QIO upon termination from a SNF, HHA or CORF.
- **Reinstatement Notice for Skilled Nursing Facility – Continued Stay** must be issued if skilled level of care is reinstated. MA SNF, HHA or CORF use is optional (approved by CMS Region IX 04/16/04, Rev. 3/05, 6/11).
- **Extension Needed for Additional Information/Tests** is used for all standard and expedited initial determinations. It should be issued when a decision is pending due to lack of information. The extension letter must not be used to pend decisions while waiting for medical records from non-contracted providers.
- **Services Requested Do Not Meet Expedited Criteria** may be issued when requested services do not meet the CMS expedited criteria definition. Use is optional.

**Additional NOMNC information:** The NOMNC is a notice that informs members of the date coverage for skilled nursing, home health or comprehensive outpatient rehabilitation services will terminate and describes what should be done if the member wishes to appeal the decision and member appeal contacts. CMS has developed a single standardized NOMNC designed to make notice delivery as simple and burden-free as possible for members. The NOMNC lists the last covered date, which must be supplied by the IPA prior to delivery.

**When to Deliver the NOMNC:** Based on the IPA's determination of when services should end, the IPA or, if delegated, the SNF, HHA, or CORF is responsible for delivering the NOMNC no later than 48 hours prior to the last covered date. If services are expected to be fewer than two days, the NOMNC should be delivered upon admission. If there is more than a two-day span between services (e.g., in the home health setting), the NOMNC should be issued on the next-to-last time services are furnished.

**How to deliver the NOMNC:** The IPA or designated SNF, HHA, or CORF must carry out "valid delivery" of the NOMNC. Valid delivery includes having a member or authorized representative sign and date the notice to acknowledge receipt. If member is incompetent, the authorized representative may be notified by telephone if personal delivery is not immediately available. In this case, the authorized representative must be informed of the last covered date of service and the member's appeal rights. The call must be documented and the

notice must be mailed to the representative the same day the telephone call was made in order to comply with CMS regulations.

**Expedited review process:** If the member decides to appeal the end of coverage, he or she must contact the QIO by no later than 12 p.m. of the day before services will end (as indicated in the NOMNC) to request a review. The QIO will inform the MA organization that the member filed an appeal so that the MA organization can immediately notify the IPA to issue the DENC the same day, in compliance with CMS regulations. The IPA may need to present additional information to assist the QIO with making a decision regarding the appeal. The QIO will notify the member of its decision no later than the effective date of the notice.

**Importance of timing/need for flexibility:** Although the regulations and accompanying CMS instructions do not require action until two days before the planned termination of covered services, it is in the best interest of the member, Humana and the IPA to facilitate delivery of the NOMNC to the enrollee as soon as the IPA determines when services will be terminated. This gives the member the maximum amount of time to decide if he/she wishes to appeal. It also allows the IPA and Humana more time to collect the required documentation. The overall deadline for record provision is close of business the day before the planned termination.

Additional assistance to patients who wish to discharge in the evening or on weekends is encouraged in the event they lose their appeal and do not want to accumulate financial liability. To facilitate a faster discharge, confirm that arrangements for follow-up care are in place, schedule equipment to be delivered if needed and write orders or instructions in advance.

**More information:** 42 C.F.R. 422.624, 422.626 and 489.27, and chapter 13 of the Medicare Managed Care Manual include information on the process as well.

**Additional information and questions:** Delegated IPAs requiring additional information about the utilization management program at Humana may call 1-800-322-2758. Select option 2 and then dial extension 1500187.

## VII. Compliance/Ethics and Fraud, Waste and Abuse

Information on these topics is covered in Humana's Provider Manual, posted online at: <https://www.humana.com/provider/support/publications>.

## Attachment A – Profile Data Fields

ROSTER FIELDS	DEFINITION OF FIELD	INSTRUCTIONS	EXAMPLE
Last name	Physician's last name	Edit last name of physician, if necessary	Smith
First name	Physician's first name	Edit first name of physician, if necessary	Lisa
Middle name or initial	Physician's middle name or initial	Enter or correct middle name initial of physician	V
Title	Degree (M.D., O.D., D.O., etc.)	Enter or correct degree of physician	M.D.
Gender	Gender of physician	Enter "M" for male or "F" for female	F
NPI	National Provider Identifier for physician	Enter or correct NPI for physician	123456789
Specialty	Specialty of physician	Enter or correct specialty of physician	Internal medicine
PCP/specialist/extender		Edit type of physician, if necessary. "PCP" for PCP; "SPC" for specialist or "EX" for extender	PCP
Effective date	Effective date of physician with IPA	Effective date of physician	1/02/2013
Tax ID	Tax identification number (TIN) of physician	Edit or correct TIN of physician	954075985
Service group name	Name of service group of physician's practice, if any. This is not IPA name.	Edit or correct practice name.	12345 Medical Group
Billing address	Billing address of physician	Edit or correct billing street address of physician's practice.	P.O. Box 123
Billing city	Billing city	Edit or correct billing city of physician's practice.	Los Angeles
Billing state	Billing state	Edit or correct billing state of physician's practice.	CA
Billing ZIP code	Billing ZIP code	Edit or correct billing ZIP code of physician's practice.	90001
Billing phone	Billing phone number	Edit or correct billing phone number of physician's practice.	(123) 456-7890
Sub-IPA name (if applicable)	Sub IPA name of IPA, often referred to as sub group or site name.	If applicable, this column will be populated. Edit/correct if physician is not part of this sub-IPA.	

Service address	Service address of participating physician	Edit or correct service street address of physician's practice.	123 Main St.
Service city	Service city of participating physician	Edit or correct service city of physician's practice.	Glendale
Service state	Service state of participating physician	Edit or correct service state of physician's practice.	CA
Service ZIP code	Service ZIP of participating physician	Edit or correct service ZIP code of physician's practice.	91204
Service phone	Service phone number of participating physician	Edit or correct service phone of physician's practice.	(098) 765-4321
Service fax	Service fax number of participating physician	Edit or correct service fax of physician's practice.	(246) 810-1214
Email address	Email address of contact at physician office, if any	Edit or correct email address of contact at physician's office.	officemanager@physicianoffice.com
Hospital privileges	Hospital privileges of physicians	Edit or correct privileges of physician.	
Open/closed panel	PCP office is open or closed to new patients	Enter "Open" or "Closed" for PCP only.	Open
Age restrictions	Age restrictions for the physician practice	Enter ages if physician only treats certain ages.	>18
Languages	Languages spoken by physician	Enter languages.	Spanish
Humana grouper	Humana assigned grouper number for sub IPA or the entire IPA (if available).		
Physician is hospital-based (Y or N)	Is the physician's practice hospital based?	Enter "Y" for yes if the physician practices only in the hospital. Enter "N" for no if the practice is not hospital based.	N
Last credentialed date	Date physician last credentialed by IPA	Effective date of physician – only required if physician is new.	12/13/2012
<b>Additional fields applicable to certain updates</b>			
Member re-assignment to new PCP	Active PCP to receive members of terminated physician	Enter name and PCP number of PCP who is accepting membership of terminated physician	#98765
Notes/comments	Notes/comments	Information you wish to provide to assist in interpreting changes reflected for this physician	
Term reason	Reason for physician leaving IPA	Examples: retired deceased or terminated	Retired



Termination date	Termination date of physicians no longer with IPA	Enter date of termination	03/15/2013
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## Attachment B

### Health Services Organization (HSO)

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#### Humana requirement for IPA authorization/denial file submission:

**Purpose:** Services for which Humana is financially responsible must have an authorization in the Humana system in order for the health care provider's claim to be paid.

If the claim presents for payment and there is no Humana authorization, the claim will be denied.

#### **Process: IPAs submit a weekly authorization report via email. Excel format is preferred.**

Approvals and denials can be included in the same report.

Humana associates create authorizations according to the IPA decision status in the authorization system so that Humana claims will adjudicate.

**Frequency needed:** Weekly

**Program method:** Excel format preferred

**Data elements required:** See table below

<u>Data Elements</u>		<u>Data Elements</u>
Member first name		Place of service
Member last name		Service type
Member DOB		DME decision (purchase/rental)
Referring provider name		Authorization validation dates (from and to)
Referring provider TIN		Decision (approved/denied)
Referring provider address		Inpatient admission date
Requested provider		Inpatient discharge date
Requested provider TIN		IPA authorization number
Requested provider address		Diagnosis code/s
Facility name		Procedure/HCP codes approved/denied *
Facility TIN		Approved/denied # of units/procedure/visits/doses of medication/months of rental/purchase item
Facility address		

**Submit via email to:** [umdeptca@humana.com](mailto:umdeptca@humana.com); [dzheng@humana.com](mailto:dzheng@humana.com); [rmenchaca@humana.com](mailto:rmenchaca@humana.com).

Please contact Don Zheng or Rick Menchaca with questions:

**Don Zheng**

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