Humana®

Virginia Commonwealth Coordinated Care (CCC) Appendix Bulletin

Effective immediately: Information for noncovered services, member transfers and member grievances and appeals

The following information provides clarifications for Providers regarding charges for noncovered services, Member transfers and disenrollment and Humana's Member grievance and appeal procedure.

- **Services that Humana Gold Plus Integrated does not cover**
  Providers may not charge Members or Medicare-Medicaid Plans (MMPs) for services that are not medically necessary or noncovered, or for which there may be other services available to meet the Member's needs. In addition, Providers may not hold the Member liable for the provision of such services if the Provider did not explain that services would be noncovered. Notwithstanding the above, if a Member agrees in advance to receive a noncovered service, then the Provider may bill the Member for those noncovered services. However, prior to rendering noncovered services, the Provider must obtain the Member's acknowledgement, in writing, of the noncovered services to be provided, the cost of such services and that the Member will be held responsible for payment.

- **Member transfers and panel closures**
  Humana will determine reasonable cause for transferring a Member based on a written request and documentation submitted by a Provider. All decisions regarding Member transfers shall be made and become effective within 60 days from the date of the request. Until such time as the transfer to another Provider is complete, the Provider is still responsible for providing that Member with necessary care and covered services. The Provider may not transfer a Member to another Provider for reasons related to the costs of providing care to that Member.

  Member transfer requests should be directed to MidAtlanticProviderRelations@humana.com.

  When closing a provider panel to new Humana MMP Members, Providers need to:
  - Give Humana prior written notice of its intent to close a provider panel, along with a specific closing date;
  - Keep the panel open to Members who were patients before the date of panel closing; and
  - Give Humana prior written notice when reopening the provider panel, along with a specific reopening date.

- **Member grievance and appeal procedure**

  The section below is taken from Humana's member grievance and appeal procedure as set forth in the Humana Member Handbook. This information is provided to you so that you may assist Humana Members in this process should they request your assistance.

  Humana has representatives who handle all Member grievances and appeals. A special set of records is kept with the reason, date and results. Humana keeps these records in the central office.

  Filing a Grievance or an Appeal

  If you have questions or an issue, call Humana Customer Care at 1-855-280-4002.

  If you are not happy with the answer you get from customer care, you can file a Grievance/Appeal. You can obtain a form or you can send a letter to Humana. If you request a form from Humana, it will be

Humana®

mailed within three working days. You can also request help from Humana to fill out the form. Note: Internal Appeals must first be exhausted before additional actions can be taken.

All Grievances/Appeals will be considered. You can have someone help you during the process, whether it is a Provider or someone you choose.

You have the right to continue services during the Grievance/Appeal process. If you choose to continue the services and the decision of the Grievance/Appeal Committee is not in your favor, you may have to pay for those services.

The Grievance/Appeal must have the following:

• Name, address, telephone number and ID number

• Facts and details of what you did to straighten out this Complaint

• What action you are looking for

• Signature

• Date

Grievance: You have the right to make a written or verbal Grievance within one year of the incident. The Grievance process may take up to 90 days. However, Humana will resolve your Grievance as quickly as your health condition requires. A letter telling you the outcome of your Grievance will go out within 90 days from the date Humana receives your request. If more time is needed, you and Humana must agree on it. If other information is needed, Humana will have 14 extra days to make a decision. Humana will send you a letter telling you about the extra time.

Appeal: You have the right to make a written or verbal Appeal; however, it must be followed up within 30 days of the date you receive a written denial. You have up to one year to file an Appeal if the denial is not in writing. The Appeal process may take up to 45 days. However, Humana will resolve your Appeal as quickly as your health condition requires. A letter telling you the outcome of your Appeal will go out within 45 days from the date Humana receives your request. If more time is needed, you and Humana must agree on it. If other information is needed, Humana will have 14 extra days to make a decision. Humana will send you a letter telling you about the extra time.

Expedited Process: You have the right to make an expedited verbal or written Grievance or Appeal. If you have a problem that is putting your life or health in danger, you or your legal spokesperson can file an “urgent” or “expedited” Appeal. These appeals are handled within 24 hours. Let the person you are talking to know that this is an “urgent” or “expedited” Appeal. You may request an expedited Appeal by calling Humana at 1-800-867-6601. If it is determined that it is not an expedited process, it will go through the normal process.

To send your Grievance or Appeal request in writing, please send it to the following address:

Humana
Attn: Grievance & Appeal Analyst
P.O. Box 14546
Lexington, KY 40512-4546

Humana®

If you wish to contact Humana's customer service department by phone, please call 1-855-235-8530. If you cannot hear or have trouble talking, call 711. We are open from 8 a.m. to 8 p.m. Monday through Friday.

If you are not in agreement with the decision, you may appeal again, utilizing an Independent Review Entity (IRE). Your appeal must be in writing within 60 days of the decision you are appealing. You, your doctor or other prescriber, or your representative can request the level 2 appeal.

If both your appeals have been turned down, you may have the right to additional levels of appeal.

The next level of the appeals process is an Administrative Law Judge (ALJ) hearing. If you want an ALJ to review your case, the item or medical service you are requesting will have to meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ to hear your appeal. If you do not agree with the ALJ's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal. If you need assistance at any stage of the appeals process, you can contact the State Long-Term Care Ombudsman at 1-800-552-3402.

You also have more appeal rights if your appeal is about services or items that might be covered by Medicaid. You can ask to appeal the Department of Medical Assistance Services (DMAS) hearing officer's decision if you do not agree with it. You must follow a two-step process as provided by Rules 2A:2 and 2A:4 of the Rules of the Supreme Court of Virginia.

- First you must file a Notice of Appeal with the director of DMAS within 30 days from the date you receive the hearing officer's decision.
- Next, you must file a Petition for Appeal in your local Circuit Court within 30 days after you file your Notice of Appeal with the DMAS director.
- The first level of court review is Circuit Court, then the Virginia Court of Appeals, and then by petition to the Virginia Supreme Court. The letter you receive with the appeal decision and the copy of Rules 2A:2 and 2A:4 of the Rules of the Supreme Court of Virginia will give you information about appealing to the Circuit Court.

For more details on member appeals and grievances, review sections 6, 7, 8 and 9 of the member handbook at http://apps.humana.com/marketing/documents.asp?file=2377661, request a copy from your provider relations representative or call Humana Customer Care at 1-855-280-4002.

If you have questions, please contact your provider representative or call Gailey Schlaefer at 1-757-617-2882.