



FLORIDA MEDICAID PROVIDER HANDBOOK

Welcome

Thank you for your participation with Humana, where our goal is to provide quality services to Medicaid enrollees.

This Florida Medicaid Provider Handbook applies to providers who provide services to Humana members with the Humana Medical Plan (Managed Medicaid Assistance Program) (MMA), Long-Term Care (LTC) Plan and Comprehensive Plan.

This provider handbook highlights the key points related to Humana's policy and procedures and is an extension to your provider agreement. It is intended to be a guideline to facilitate and inform you and your staff of the requirements of Florida MMA, LTC and Comprehensive plans, what we need from you, and what you can expect from Humana. The guidelines outlined in this provider handbook are designed to assist you in providing caring, responsive service to our Humana members. Please note that the information under Section I – Humana Medical Plan (MMA) supplements the Provider Manual for Physicians, Hospitals and Health Care providers located at Humana.com/publications.

You will be notified of updates to this handbook via bulletins and notices posted on our website at Humana.com/publications. If you need further explanation on topics discussed in this handbook, please contact your local provider relations representative or contract specialist.

We look forward to a long and productive relationship with you and your staff.

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SECTION I – HUMANA MEDICAL PLAN

PROGRAM DESCRIPTION

Florida has offered Medicaid services since 1970. Medicaid provides health care coverage for income-eligible children, seniors, disabled adults and pregnant women. It is funded by both the state and federal governments and includes both capitated health plans as well as fee-for-service coverage. The Agency for Health Care Administration (AHCA) is responsible for administering the Medicaid program and will administer contracts, monitor Health Plan performance and provide oversight in all aspects of Health Plan operations. The state has sole authority for determining eligibility for Medicaid and whether Medicaid recipients are required to enroll in, may volunteer to enroll in, may not enroll in a Medicaid health plan or are subject to annual enrollment.

The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services. This program is referred to as statewide Medicaid managed care (SMMC).

In entering into a Contract with AHCA to provide services to Medicaid beneficiaries, Humana has agreed to comply with the provisions of the Medicaid Contract (the “Contract”) as well as with all applicable Agency rules relating to the Contract and the applicable provisions in the Florida Medicaid Handbooks (“Handbooks”).

Humana’s obligations under the Contract include, but are not limited to:

- Maintaining a quality improvement program aimed at improving the quality of member outcomes.
- Maintaining quality management and utilization management programs.
- Furnishing AHCA with data as required under the Contract and as may be required in additional ad hoc requests.
- Collecting and submitting encounter data in the format and in the time frames specified by AHCA.

In signing this contract, Humana has been authorized to take whatever steps are necessary to ensure that providers are recognized by the State Medicaid program, including its Choice Counseling/Enrollment Broker contractor(s) as a participating provider of Humana. In addition, Humana has the responsibility to ensure providers’ submission of encounter data is accepted by the Florida Medicaid Management Information System (MMIS) and/or the State’s encounter data warehouse.

The Florida Medicaid program is implementing a new system through which Medicaid enrollees will receive services. This program is called the Statewide Medicaid Managed Care Managed Medical Assistance program. The Managed Medical Assistance (MMA) program is comprised of several types of managed care plans:

- Health Maintenance Organizations
- Provider Service Networks
- Children's Medical Services Network
- Most Medicaid recipients must enroll in the MMA program

The following individuals are NOT required to enroll, although they may enroll if they choose to:

- Medicaid recipients who have other creditable health care coverage, excluding Medicare
- Persons eligible for refugee assistance
- Medicaid recipients who are residents of a developmental disability center
- Medicaid recipients enrolled in the developmental disabilities home- and community-based services
- Waiver or Medicaid recipients waiting for waiver services

To be a participating provider, you must be a Medicaid-registered provider who provides services in one of the following regions:

- Region 1: Escambia, Okaloosa, Santa Rosa and Walton counties
- Region 6: Hardee, Highlands, Hillsborough, Manatee and Polk counties
- Region 9: Indian River, Martin, Okeechobee, Palm Beach and St. Lucie counties
- Region 10: Broward County
- Region 11: Miami-Dade and Monroe counties

Florida's Managed Medical Assistance (MMA) program is designed to implement a new statewide managed care delivery system that will improve outcomes, improve consumer satisfaction and reduce and control costs.

The Florida MMA program will focus on four key objectives in order to support successful implementation:

1. Preserving continuity of care.
2. Requiring sufficient and accurate networks under contract and taking patients, allowing for an informed choice of plans for recipients and the ability to make appointments.
3. Paying providers fully and promptly to preclude provider cash flow or payroll issues, and to give providers ample opportunity to learn and understand the plan's prior authorization procedures.
4. Coordinating with the Choice Counseling Call Center and website operated by the Agency's contracted enrollment broker.

DEFINITIONS

The following are definitions that are specific to this Appendix:

Abuse (for program integrity functions) — Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or recipient practices that result in unnecessary cost to the Medicaid program.

Abuse, Neglect and Exploitation — In accordance with Chapter 415, F.S., and Chapter 39, F.S.:

“Abuse” means any willful act or threatened act by a caregiver that causes or is likely to cause significant impairment to an enrollee’s physical, mental or emotional health. Abuse includes acts and omissions.

“Exploitation” of a vulnerable adult means a person who:

1. Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult’s funds, assets or property for the benefit of someone other than the vulnerable adult.
2. Knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, the vulnerable adult’s funds, assets or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit or possession of the funds, assets or property for the benefit of someone other than the vulnerable adult.

“Neglect” of an adult means the failure or omission on the part of the caregiver to provide the care, supervision, and services necessary to maintain the physical and behavioral health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision and medical services, that a prudent person would consider essential for the well-being of the vulnerable adult. The term “neglect” also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect or exploitation by others. “Neglect” is repeated conduct or a single incident of carelessness that produces, or could reasonably be expected to result in, serious physical or psychological injury or a substantial risk of death.

“Neglect” of a child occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment, or a child is permitted to live in an environment when such deprivation or environment causes the child’s physical, behavioral or emotional health to be significantly impaired or to be in danger of being significantly impaired.

Action — The denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b). The reduction, suspension or termination of a previously authorized service. The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner, as defined by the state. The failure of the Managed Care Plan to act within ninety (90) days from the date the Managed Care Plan receives a grievance, or forty-five (45) days from the date the Managed Care Plan receives an appeal. For a resident of a rural area with only one (1) managed care entity, the denial of an enrollee’s request to exercise the right to obtain services outside the network.

Acute Care Services — Short-term medical treatment that may include, but is not limited to, community behavioral health, dental, hearing, home health, independent laboratory and X-ray, inpatient hospital, outpatient hospital/emergency medical, practitioner, prescribed drug, vision or hospice services.

Adjudicated Claim — A claim for which a determination has been made to pay or deny the claim.

Advance Directive — A written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

Advanced Registered Nurse Practitioner (ARNP) — A licensed advanced practice registered nurse who works in collaboration with a practitioner according to Chapter 464, F.S., according to protocol, to provide diagnostic and clinical interventions. An ARNP must be authorized to provide these services by Chapter 464, F.S., and protocols filed with the Board of Medicine.

Adverse Incident — An injury of an enrollee occurring during delivery of Managed Care Plan covered services that:

1. Is associated in whole or in part with service provision rather than the condition for which such service provision occurred; and,
2. Is not consistent with or expected to be a consequence of service provision; or
3. Occurs as a result of service provision to which the patient has not given his informed consent; or
4. Occurs as the result of any other action or lack thereof on the part of the staff of the provider.

After Hours — The hours between 5 p.m. and 8 a.m. local time, Monday through Friday inclusive, and all day Saturday and Sunday. State holidays are included.

Agency — State of Florida, Agency for Health Care Administration or its designee.

Aging and Disability Resource Center (ADRC) — An agency designated by the DOEA to develop and administer a plan for a comprehensive and coordinated system of services for older and disabled persons.

Ancillary Provider — A provider of ancillary medical services who has contracted with a Managed Care Plan to serve the Managed Care Plan's enrollees.

Appeal — A request for review of an action, pursuant to 42 CFR 438.400(b).

Area Agency on Aging — An agency designated by the DOEA to develop and administer a plan for a comprehensive and coordinated system of services for older persons.

Behavioral Health Care Provider — A licensed or certified behavioral health professional, such as a clinical psychologist under Chapter 490, F.S., clinical social worker, mental health professional under Chapter 491, F.S.; certified addictions professional; or registered nurse qualified due to training or competency in behavioral health care, who is responsible for the provision of behavioral health care to patients, or a physician licensed under Chapters 458 or 459, F.S., who is under contract to provide behavioral health services to enrollees.

Behavioral Health Services — Services listed in the Community Behavioral Health Services Handbook and the Mental Health Targeted Case Management Coverage and Limitations Handbook as specified in Section V, Covered Services and the MMA Exhibit.

Beneficiary Assistance Program — A state external conflict resolution program authorized under s. 409.91211(3)(q), F.S., available to Medicaid participants, that provides an additional level of appeal if the Managed Care Plan’s process does not resolve the conflict.

Benefits — A schedule of health care services to be delivered to enrollee covered by the Health Plan as set forth in Section V of the MMA contract and Section Two (2) of this Appendix.

Business Days — Traditional workdays, which are Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded.

Calendar Days — All seven days of the week. Unless otherwise specified, the term “days” in this attachment refers to calendar days.

Care Coordination/Case Management — A process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an enrollee’s health needs using communication and all available resources to promote quality outcomes. Proper care coordination/case management occurs across a continuum of care, addressing the ongoing individual needs of an enrollee rather than being restricted to a single practice setting.

Case Record — A record that includes information regarding the management of services for an enrollee including the plan of care and documentation of care coordination/case management activities.

Cause — Special reasons that allow mandatory enrollees to change their Managed Care Plan choice outside their open enrollment period. May also be referred to as “good cause.” (See 59G-8.600, F.A.C.)

Centers for Medicare & Medicaid Services (CMS) — The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children’s Health Insurance Program under Title XXI of the Social Security Act.

Certification — The process of determining that a facility, equipment or an individual meets the requirements of federal or state law, or whether Medicaid payments are appropriate or shall be made in certain situations.

Child Health Checkup Program (CHCUP) — Comprehensive and preventive health examinations provided on a periodic basis that are aimed at identifying and correcting medical conditions in children/adolescents. Policies and procedures are described in the Child Health Checkup Services Coverage and Limitations Handbook.

Children/Adolescents — Enrollees under the age of 21.

Children’s Medical Services Network — A primary care case management program for children from birth through age 21 with special health care needs, administered by the Department of Health for physical health services and the Department of Children and Families for behavioral health.

Children’s Medical Services (CMS) Plan — A Medicaid specialty plan for children with chronic conditions operated by the Florida Department of Health’s Children’s Medical Services Network as specified in s. 409.974(4), F.S., through a single, statewide contract with the agency that is not subject to the SMMC procurement requirements, or regional plan limits, but must meet all other plan requirements for the MMA program.

Claim — (1) A bill for services, (2) a line item of service, or (3) all services for one (1) recipient within a bill, pursuant to 42 CFR 447.45, in a format prescribed by the Agency through its Medicaid provider handbooks.

Clean Claim — A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 CFR 447.45.

Commission for the Transportation Disadvantaged (CTD) — An independent commission housed administratively within the Florida Department of Transportation. The CTD’s mission is to ensure the availability of efficient, cost-effective, and quality transportation services for transportation-disadvantaged persons.

Community Care for the Elderly Lead Agency — An entity designated by an Area Agency on Aging and given the authority and responsibility to coordinate services for functionally impaired elderly persons.

Community Outreach — The provision of health or nutritional information or information for the benefit and education of, or assistance to, a community in regard to health-related matters or public awareness that promotes healthy lifestyles. Community outreach also includes the provision of information about health care services, preventive techniques and other health care projects and the provision of information related to health, welfare and social services or social assistance programs offered by the state of Florida or local communities.

Community Outreach Materials — Materials regarding health or nutritional information or information for the benefit and education of, or assistance to, a community on health-related matters or public awareness that promotes healthy lifestyles. Such materials are meant specifically for the community at large and may also include information about health care services, preventive techniques, and other health care projects and the provision of information related to health, welfare and social services or social assistance programs offered by the State of Florida or local communities. Community outreach materials are limited to brochures, fact sheets, billboards, posters and ad copy for radio, television, print or the Internet.

Community Outreach Representative — A person who provides health information, information that promotes healthy lifestyles, information that provides guidance about social assistance programs, and information that provides culturally and linguistically appropriate health or nutritional education. Such representatives must be appropriately trained, certified and/or licensed, including but not limited to, social workers, nutritionists, physical therapists and other health care professionals.

Complaint — Any oral or written expression of dissatisfaction by an enrollee submitted to the Health Plan or to a state agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships, such as rudeness of a provider or Health Plan employee, failure to respect the enrollee’s rights, Health Plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the Health Plan’s Contract. A complaint is an informal component of the grievance system.

Continuous Quality Improvement — A management philosophy that mandates continually pursuing efforts to improve the quality of products and services produced by an organization.

Contract, Medical Assistance — As a result of receiving a regional award from the Agency pursuant to s. 409.966(2), F.S., and/or s. 409.974, F.S., and successfully meeting all plan readiness requirements, the agreement between the Managed Care Plan and the Agency where the Managed Care Plan will provide Medicaid-covered services to enrollees, comprising the Contract and any addenda, appendices, attachments, or amendments thereto, and be paid by the Agency as described in the terms of the agreement. Also referred to as the “Contract.”

County Health Departments (CHD) — CHDs are organizations administered by the Department of Health for the purpose of providing health services as defined in Chapter 154, F.S., which include the promotion of the public’s health, the control and eradication of preventable diseases and the provision of primary health care for special populations.

Coverage and Limitations Handbook and/or Provider General Handbook (Handbook) — A Florida Medicaid document that provides information to a Medicaid provider about enrollee eligibility; claims submission and processing; provider participation; covered care, goods and services; limitations; procedure codes and fees; and other matters related to participation in the Medicaid program.

Covered Services — Those services provided by the Health Plan in accordance with the Health Plan’s Medicaid Contract, and as outlined in Section V of the MMA contract and in Section Two (2) Covered Services of this Appendix.

Crisis Support — Services for persons initially perceived to need emergency behavioral health services, but upon assessment, do not meet the criteria for such emergency care. These are acute care services available twenty-four hours a day, seven days a week (24/7) for intervention. Examples include: mobile crisis, crisis/emergency screening, crisis hotline and emergency walk-in.

Department of Children and Families (DCF) — The state agency responsible for overseeing programs involving behavioral health, child care, family safety, domestic violence, economic self-sufficiency, refugee services, homelessness and programs that identify and protect abused and neglected children and adults.

Department of Elder Affairs (DOEA) — The primary state agency responsible for administering human services programs to benefit Florida’s elders and developing policy recommendations for long-term care in addition to overseeing the implementation of federally funded and state-funded programs and services for the state’s elderly population.

Department of Health — The state agency responsible for public health, public primary care and personal health, disease control, and licensing of health professionals.

Direct Secure Messaging (DSM) — Enables Managed Care Organizations and providers to securely send patient health information to many types of organizations.

Direct Service Behavioral Health Care Provider — An individual qualified by training or experience to provide direct behavioral health services.

Disease Management — A system of coordinated health care intervention and communication for populations with conditions in which patient self-care efforts are significant. Disease management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Disenrollment — The Agency-approved discontinuance of an enrollee's participation in a Managed Care Plan.

Downward Substitution — The use of less restrictive, lower cost services than otherwise might have been provided, that are considered clinically acceptable and necessary to meet specified objectives outlined in an enrollee's plan of treatment, provided as an alternative to higher cost services.

Dual Eligible — An enrollee who is eligible for both Medicaid (Title XIX) and Medicare (Title XVIII) programs.

Durable Medical Equipment (DME) — Medical equipment that can withstand repeated use, is customarily used to serve a medical purpose, is generally not useful in the absence of illness or injury and is appropriate for use in the enrollee's home.

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) — As defined by 42 CFR 440.40(b) (2012) or its successive regulation, means: (1) Screening and diagnostic services to determine physical or mental defects in recipients under age 21; and (2) Health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. Pursuant to s. 42 CFR 441.56 (2012) or its successive regulation, this is a program about which all eligible individuals and their families must be informed. EPSDT includes screening (periodic comprehensive child health assessments) consisting of regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. As a minimum, these screenings must include, but are not limited to: (a) comprehensive health and developmental history, (b) comprehensive unclothed physical examination, (c) appropriate vision testing, (d) appropriate hearing testing, (e) appropriate laboratory tests, (f) dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age.

Screening services must be provided in accordance with reasonable standards of medical and dental practice determined by the Agency after consultation with recognized medical and dental organizations involved in child health care. Requirements for screenings are contained in the Medicaid Child Health Checkup Coverage and Limitations handbook. Diagnosis and treatment include: (a) diagnosis of and

treatment for defects in vision and hearing, including eyeglasses and hearing aids; (b) dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and (c) appropriate immunizations. (If it is determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time.) (See definition of Child Health Check-up program.)

Early Intervention Services (EIS) — A Medicaid program designed for children receiving services through the Department of Health’s Early Steps program. Early Steps serves eligible infants and toddlers from birth to thirty-six (36) months who have development delays or a condition likely to result in a developmental delay. EIS services are authorized in the child’s Early Steps Individualized Family Support Plan and are delivered by Medicaid-enrolled EIS providers throughout the state.

Emergency Behavioral Health Services — Those services required to meet the needs of an individual who is experiencing an acute crisis, resulting from a mental illness, which is a level of severity that would meet the requirements for an involuntary examination (see s. 394.463, F.S.), and in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

Emergency Medical Condition — A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the health of a patient, including a pregnant woman or fetus;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.
- With respect to a pregnant woman:
 - That there is inadequate time to affect safe transfer to another hospital prior to delivery;
 - That a transfer may pose a threat to the health and safety of the patient or fetus;
 - That there is evidence of the onset and persistence of uterine contractions or rupture of other membranes, Section 395.002.F.S.

Emergency Services and Care — Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If an emergency medical condition exists, emergency services and care includes the care or treatment that is necessary to relieve or eliminate the emergency medical condition within the service capability of the facility.

Emergency Transportation — The provision of emergency transportation services in accordance with s. 409.908 (13)(c)4., F.S.

Encounter Data — A record of diagnostic or treatment procedures or other medical, allied, or long-term care provided to the Managed Care Plan’s Medicaid enrollees, excluding services paid by the Agency on a fee-for-service basis.

Enrollee — A Medicaid recipient currently enrolled in the Health Plan.

Enrollees with Special Health Care Needs — Enrollees who face physical, behavioral or environmental challenges daily that place at risk their health and ability to fully function in society. This includes individuals with mental retardation or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care; and all enrollees in LTC Managed Care Plans.

Enrollment — The process by which an eligible Medicaid recipient signs up to participate in a Managed Care Plan.

Enrollment Broker — The state’s contracted or designated entity that performs functions related to outreach, education, enrollment, and disenrollment of potential enrollees into a Managed Care Plan.

Enrollment Specialists — Individuals, authorized through an Agency-approved process, who provide one-on-one information to Medicaid recipients to help them choose the Managed Care Plan that best meets the health care needs of them and their families.

Expanded Benefit — A benefit offered to all enrollees in specific population groups, covered by the Managed Care Plan for which the Managed Care Plan receives no direct payment from the Agency. These specific population groups are as follows: TANF; SSI No Medicare, non-LTC eligible; SSI with Medicare, non-LTC eligible; Dual Eligible, LTC eligible; Medicaid Only, LTC eligible; HIV/AIDS Specialty Population, with Medicare; HIV/AIDS Specialty Population, No Medicare; and Child Welfare Specialty Population.

Expedited Appeal Process — The process by which the appeal of an action is accelerated because the standard time frame for resolution of the appeal could seriously jeopardize the enrollee’s life, health or ability to obtain, maintain or regain maximum function.

External Quality Review (EQR) — The analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness and access to the health care services that are furnished to Medicaid recipients by a Health Plan.

External Quality Review Organization (EQRO) — An organization that meets the competence and independence requirements set forth in federal regulation 42 CFR 438.354, and performs external quality review (EQR), other related activities as set forth in federal regulations or both.

Facility-based — As the term relates to services, services the enrollee receives from a residential facility in which the enrollee lives. Under this Contract, assisted living facility services, assistive care services, adult family care homes and nursing facility care are facility-based services.

Federally Qualified Health Center (FQHC) — An entity that is receiving a grant under section 330 of the Public Health Service Act, as amended. (Also see s. 1905(l)(2)(B) of the Social Security Act.) FQHCs provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.

Fee-for-Service (FFS) — A method of making payment by which the Agency sets prices for defined medical or allied care, goods or services.

Fee Schedule — A list of medical, dental or mental health services or products covered by the Florida Medicaid program, which provide the associated reimbursement rates for each covered service or product and are promulgated into rule.

Florida Mental Health Act — Includes the Baker Act that covers admissions for persons who are considered to have an emergency mental health condition (a threat to themselves or others) as specified in ss. 394.451 through 394.47891, F.S.

Fraud — An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to that person or another person. The term includes any act that constitutes fraud under applicable federal or state law.

Full Benefit Dual Eligible — An enrollee who is eligible for full Medicaid benefits under Medicaid (Title XIX) and Medicare (Title XVIII) programs.

Functional Status — The ability of an individual to perform self-care, self-maintenance and physical activities in order to carry on typical daily activities.

Grievance — An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships, such as rudeness of a provider or employee or failure to respect the enrollee's rights.

Grievance Process — The procedures for addressing enrollees' grievances.

Grievance System — The system for reviewing and resolving enrollee complaints, grievances and appeals. Components must include a complaint process, a grievance process, an appeal process, access to an applicable review outside the Managed Care Plan (Beneficiary Assistance Program) and access to a Medicaid Fair Hearing through the Department of Children and Families.

Health Assessment — A complete health evaluation combining health history, physical assessment and the monitoring of physical and psychological growth and development.

Health Care-Acquired Condition (HCAC) — A condition, occurring in any inpatient hospital or inpatient psychiatric hospital setting, including crisis stabilization units (CSUs), identified as a hospital-acquired condition (HAC) by the Secretary of Health and Human Services under section 1886(d)(4)(D)(iv) of the Social Security Act for purposes of the Medicare program as specified in the Florida Medicaid State Plan. By federal law, Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE), as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients, are not reportable Provider-Preventable Conditions (PPCs)/ Health Care-Acquired Conditions (HCACs). HCACs also include never events.

Health Care Professional — A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical

nurse specialist, certified registered nurse anesthetist and certified nurse midwife), a licensed clinical social worker, registered respiratory therapist and certified respiratory therapy technician.

Healthcare Effectiveness Data and Information Set (HEDIS®) — The data and information set developed and published by the National Committee for Quality Assurance. HEDIS includes technical specifications for the calculation of performance measures.

Health Information Exchange (HIE) — The secure, electronic exchange of health information among authorized stakeholders in the health care community — such as care providers, patients and public health agencies — to drive timely, efficient, high-quality, preventive and patient-centered care.

Health Information Technology for Economic and Clinical Health (HITECH) Act — The Health Information Technology Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.

Healthy Behaviors (MMA Managed Care Plans Only) — A program offered by Managed Care Plans that encourages and rewards behaviors designed to improve the enrollee’s overall health.

Health Fair — An event conducted in a setting that is open to the public or segment of the public (such as the “elderly” or “schoolchildren”) during which information about health care services, facilities, research, preventive techniques or other health care subjects is disseminated. At least one (1) community organization or two (2) health-related organizations that are not affiliated under common ownership must actively participate in the health fair.

Hospital — A facility licensed in accordance with the provisions of Chapter 395, F.S., or the applicable laws of the state in which the service is furnished.

Licensed — A facility, equipment or an individual that has formally met state, county and local requirements, and has been granted a license by a local, state or federal government entity.

Licensed Practitioner of the Healing Arts — A psychiatric nurse, registered nurse, advanced registered nurse practitioner, physician assistant, clinical social worker, mental health counselor, marriage and family therapist, or psychologist.

List of Excluded Individuals and Entities (LEIE) — A database maintained by the Department of Health & Human Services, Office of the Inspector General. The LEIE provides information to the public, health care providers, patients and others relating to parties excluded from participation in Medicare, Medicaid and all other federal health care programs.

Managed Behavioral Health Organization (MBHO) — A behavioral health care delivery system managing quality, utilization and cost of services. Additionally, an MBHO measures performance in the area of mental disorders.

Managed Care Plan — An eligible plan under Contract with the Agency to provide services in the MMA Statewide Medicaid Managed Care Program.

Mandatory Assignment — The process the Agency uses to assign enrollees to a Managed Care Plan. The Agency automatically assigns those enrollees required to be in a Managed Care Plan who did not voluntarily choose one.

Mandatory Enrollee — The categories of eligible Medicaid recipients who must be enrolled in a Managed Care Plan.

Mandatory Potential Enrollee — A Medicaid recipient who is required to enroll in a Managed Care Plan but has not yet made a choice.

Marketing — Any activity or communication conducted by or on behalf of any Managed Care Plan with a Medicaid recipient who is not enrolled with the Managed Care Plan or an individual potentially eligible for Medicaid that can reasonably be interpreted as intended to influence such individual to enroll in the particular Managed Care Plan.

Medicaid — The medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., and regulations thereunder, as administered in the state of Florida by the Agency under 409.901 et seq., F.S.

Medicaid Fair Hearing — An administrative hearing conducted by DCF to review an action taken by a Managed Care Plan that limits, denies, or stops a requested service.

Medicaid Program Integrity (MPI) — The unit of the Agency responsible for preventing and identifying fraud and abuse in the Medicaid program.

Medicaid Recipient — Any individual whom the DCF, or the Social Security Administration on behalf of the DCF, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods or services for which the Agency may make payments under the Medicaid program, and who is enrolled in the Medicaid program.

Medicaid State Plan — A written plan between a state and the federal government that outlines the state's Medicaid eligibility standards, provider requirements, payment methods, and health benefit packages. A Medicaid State Plan is submitted by each state and approved by the Centers for Medicare & Medicaid Services (CMS).

Managed Medical Assistance (MMA) Plan — A Managed Care Plan that provides the services described in s. 409.973, F.S., for the MMA Statewide Medicaid Managed Care (SMMC) program.

Medical/Case Record — Documents corresponding to medical or allied care, goods or services furnished in any place of business. The records may be on paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media.

Medically Complex — An individual who is medically fragile who may have multiple comorbidities or be technologically dependent on medical apparatus or procedures to sustain life.

Medically Necessary or Medical Necessity — Services that include medical or allied care, goods or services furnished or ordered to meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
- Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs;

- Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational;
- Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker or the provider.

Medically Necessary or Medical Necessity for those services furnished in a hospital on an inpatient basis cannot, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended or approved medical or allied goods or a service does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

Medicare — The medical assistance program authorized by Title XVIII of the Social Security Act.

Medicare Advantage Plan — A Medicare-approved health plan offered by a private company that covers both hospital and medical services, often includes prescription drug coverage, and may offer extra coverage such as vision, hearing, dental and/or wellness programs. Each plan can charge different out-of-pocket costs and have different rules for how to get services. Such plans can be organized as health maintenance organizations, preferred provider organizations, coordinated care plans and special needs plans.

Mental Health Targeted Case Manager — An individual who provides mental health targeted case management services directly to or on behalf of an enrollee on an individual basis in accordance with 65E-15, F.A.C., and the Florida Medicaid Mental Health Targeted Case Management Coverage and Limitations Handbook.

National Provider Identifier (NPI) — An identification number assigned through the National Plan and Provider Enumerator System of the federal Department of Health & Human Services. NPIs can be obtained online at <https://nppes.cms.hhs.gov>.

Never Event (NE) — As defined by the National Quality Forum (NQF), an error in medical care that is of concern to both the public and health care professionals and providers, clearly identifiable and measurable (and thus feasible to include in a reporting system), and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization. Currently, in Florida Medicaid, never event health care settings are limited to inpatient hospitals and inpatient psychiatric hospitals, including CSUs.

Newborn — A live child born to an enrollee, who is an enrollee of the Health Plan.

Noncovered Service — A service that is not a covered service/benefit.

Nonparticipating Provider — A person or entity eligible to provide Medicaid services that does not have a contractual agreement with the Managed Care Plan to provide services. In order to receive payment for covered services, non-participating providers must be eligible for a Medicaid provider agreement

and recognized in the Medicaid system (Florida MMIS) as either actively enrolled Medicaid providers or as Managed Care Plan registered providers.

Normal Business Hours — The hours between 8 a.m. and 5 p.m. local time, Monday — Friday inclusive. State holidays are excluded.

Nursing Facility — An institutional care facility that furnishes medical or allied inpatient care and services to individuals needing such services.

Other Provider-preventable Condition (OPPC) — A condition occurring in any health care setting that:

- Is identified in the Florida Medicaid State Plan;
- Is reasonably preventable through the application of procedures supported by evidence-based guidelines;
- Has a negative consequence for the beneficiary;
- Is auditable; and
- Includes, at a minimum, the following:
 - Wrong surgical or other invasive procedure performed on a patient;
 - Surgical or other invasive procedure performed on the wrong body part; and
 - Surgical or other invasive procedure performed on the wrong patient.

Outpatient — A patient of an organized medical facility, or distinct part of that facility, who is expected by the facility to receive, and who does receive, professional services for less than a 24-hour period, regardless of the hours of admission, whether or not a bed is used and/or whether or not the patient remains in the facility past midnight.

Overpayment — Overpayment defined in accordance with s. 409.913, F.S., includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

Participating Provider — A health care practitioner or entity authorized to do business in Florida and contracted with the Managed Care Plan to provide services to the Managed Care Plan's enrollees.

Participating Specialist — A physician, licensed to practice medicine in the State of Florida, who contracts with the Health Plan to provide specialized medical services to the Health Plan's enrollees.

Patient Responsibility — The cost of Medicaid long-term care services not paid for by the Medicaid program, for which the enrollee is responsible. Patient responsibility is the amount enrollees must contribute toward the cost of their care. This is determined by the DCF's Economic Self Sufficiency only and is based on income and type of placement.

Peer Review — An evaluation of the professional practices of a provider by the provider's peers. The evaluator assesses the necessity, appropriateness and quality of care furnished by comparing the care to that customarily furnished by the provider's peers and to recognized health care standards.

Person (entity) — Any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

Physician Assistant (PA) — A person who is a graduate of an approved program or its equivalent or meets standards approved by the Board of Medicine or the Board of Osteopathic Medicine, and is certified to perform medical services delegated by the supervising physician in accordance with Chapter 458, F.S.

Physicians' Current Procedural Terminology (CPT®) — A systematic listing and coding of procedures and services published annually by the American Medical Association.

Portable X-ray Equipment — X-ray equipment transported to a setting other than a hospital, clinic or office of a physician or other licensed practitioner of the healing arts.

Post-stabilization Care Services — Covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain, improve or resolve the enrollee's condition pursuant to 42 CFR 422.113.

Potential Enrollee — Pursuant to 42 CFR 438.10(a), an eligible Medicaid recipient who is subject to mandatory assignment or who may voluntarily elect to enroll in a given Managed Care Plan, but is not yet an enrollee of a specific Managed Care Plan.

Pre-enrollment — The provision of marketing materials to a Medicaid recipient.

Preferred Drug List — A listing of prescription products selected by a pharmaceutical and therapeutics committee as cost-effective choices for clinician consideration when prescribing for Medicaid recipients.

Prescribed Pediatric Extended Care (PPEC) — A nonresidential health care center for children who are medically complex or technologically dependent and require continuous therapeutic intervention or skilled nursing services.

Primary Care — Comprehensive, coordinated and readily accessible medical care including health promotion and maintenance; treatment of illness and injury; early detection of disease; and referral to specialists when appropriate.

Primary Care Case Management — The provision or arrangement of enrollees' primary care and the referral of enrollees for other necessary medical services on a twenty-four (24) hour basis.

Primary Care Provider (PCP) — A Health Plan staff or contracted physician practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioner, physician assistant or other specialty approved by the Agency, who furnishes primary care and patient management services to an enrollee.

Primary Dental Provider (PDP) — A Managed Care Plan staff or subcontracted dentist practicing as a general dentist or pediatric dentist who furnishes primary dental care and patient management services to an enrollee.

Prior Authorization — The act of authorizing specific services before they are rendered.

Protected Health Information (PHI) — For purposes of this attachment, protected health information shall have the same meaning and effect as defined in 45 CFR 160 and 164, limited to the information created, received, maintained or transmitted by the Managed Care Plan from, or on behalf of, the Agency.

Protocols — Written guidelines or documentation outlining steps to be followed for handling a particular situation, resolving a problem or implementing a plan of medical, nursing, psychosocial, developmental and educational services.

Provider — A person or entity that has a Medicaid provider agreement in effect with the Agency, and a contractual agreement with the Health Plan.

Provider-preventable Condition (PPC) — A condition that meets the definition of a health care-acquired condition or other provider-preventable condition as defined in 42 CFR 447.26(b). PPCs include health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs) in inpatient hospital and inpatient psychiatric hospital settings, including crisis stabilization units (CSUs).

Provider Contract — An agreement between the Health Plan and a health care provider as described above.

Public Event — An event that is organized or sponsored by an organization for the benefit and education of or assistance to a community in regard to health-related matters or public awareness. A Managed Care Plan may sponsor a public event if the event includes active participation of at least one (1) community organization or two (2) health-related organizations not affiliated with the Managed Care Plan.

Quality — The degree to which a Health Plan increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Enhancements — Certain health-related, community-based services that the Managed Care Plan must offer and coordinate access to its enrollees. Managed Care Plans are not reimbursed by the Agency/Medicaid for these types of services.

Quality Improvement (QI) — The process of monitoring and ensuring that the delivery of health care services are available, accessible, timely, medically necessary, and provided in sufficient quantity, of acceptable quality, within established standards of excellence and appropriate for meeting the needs of the enrollees.

Region — The designated geographical area within which the Managed Care Plan is authorized by the Contract to furnish covered services to enrollees. The Managed Care Plan must serve all counties in the Region(s) for which it is contracted. The 67 Florida counties are divided into 11 regions pursuant to s. 409.966(2), F.S. May also be referred to as “service area.”

Registered Nurse (RN) — An individual who is licensed to practice professional nursing in accordance with Chapter 464, F.S.

Registered Provider — A provider that is registered with FMMIS via the Managed Care Plan. Such providers cannot bill Medicaid through fee-for-service claims submissions. Registered providers are assigned a Medicaid provider identification number for encounter data purposes only.

Remediation — The act or process of correcting a fault or deficiency.

Risk Adjustment (also Risk-adjusted) — In a managed health care setting, risk adjustment of capitation payments is the process used to distribute capitation payments across Managed Care Plans based on the expected health risk of the members enrolled in each Managed Care Plan.

Risk Assessment — The process of collecting information from a person about hereditary, lifestyle and environmental factors to determine specific diseases or conditions for which the person is at risk.

Rural — An area with a population density of less than one hundred (100) individuals per square mile, or an area defined by the most recent United States Census as rural, i.e., lacking a metropolitan statistical area (MSA).

Rural Health Clinic (RHC) — A clinic that is located in an area that has a health care provider shortage. An RHC provides primary health care and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services. An RHC employs, contracts or obtains volunteer services from licensed health care practitioners to provide services.

Sanctions — In relation to Section VIII.F: Any monetary or non-monetary penalty imposed upon a provider, entity or person (e.g., a provider entity or person being suspended from the Medicaid program). A monetary sanction under Rule 59G-9.070, F.A.C. may be referred to as a “fine.” A sanction may also be referred to as a disincentive.

Screen or Screening — A brief process, using standardized health screening instruments, used to make judgments about an enrollee’s health risks in order to determine if a referral for further assessment and evaluation is necessary.

Serious Injury — Any significant impairment of the physical condition of the patient as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Service Authorization — The Managed Care Plan’s approval for services to be rendered. The process of authorization must at least include an enrollee’s or a provider’s request for the provision of a service.

Service Delivery Systems — Mechanisms that enable provision of certain health care benefits and related services for Medicaid recipients as provided in s. 409.973, F.S., which include, but are not limited to, the Medicaid fee-for-service program and the Medicaid Managed Medical Assistance Program.

Sick Care — Non-urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease).

Special Supplemental Nutrition Program for Women, Infants and Children (WIC) — Program administered by the Department of Health that provides nutritional counseling, nutritional education, breast-feeding promotion and nutritious foods to pregnant, postpartum and breast-feeding women, infants and children up to the age of 5 who are determined to be at nutritional risk and who have a low-to-moderate income. An individual who is eligible for Medicaid is automatically income-eligible for WIC benefits. Additionally, WIC income eligibility is automatically provided to an enrollee’s family that includes a pregnant woman or infant certified eligible to receive Medicaid.

Spoken Script — Standardized text used by Managed Care Plan staff in verbal interactions with enrollees and/or potential enrollees designed to provide information and/or to respond to questions and requests. Spoken scripts also include interactive voice recognition (IVR) and on-hold messages. Marketing scripts are intended to influence such individuals to enroll in the particular Managed Care Plan.

State — State of Florida.

Statewide Inpatient Psychiatric Program (SIPP) — A twenty-four (24) hour inpatient residential treatment program funded by Medicaid that provides mental health services to children under twenty-one (21) years of age.

Subcontract — An agreement entered into by the Health Plan for provision of some of its functions, services or responsibilities for providing services under this Contract.

Subcontractor — Any person or entity with which the Health Plan has contracted or delegated some of its functions, services or responsibilities for providing services under this Contract.

Temporary Assistance to Needy Families (TANF) — Public financial assistance provided to low-income families through DCF.

Temporary Loss Period — Period in which an enrollee loses eligibility and regains it, allowing the recipient to be re-enrolled in the Managed Care Plan in which the recipient was enrolled prior to the eligibility loss.

Transportation — An appropriate means of conveyance furnished to an enrollee to obtain Medicaid authorized/ covered services.

Unborn Activation — The process by which an unborn child, who has been assigned a Medicaid ID number, is made Medicaid eligible upon birth.

Urban — An area with a population density of greater than 100 individuals per square mile or an area defined by the most recent United States Census as urban, i.e., as having a metropolitan statistical area (MSA).

Urgent Behavioral Health Care — Those situations that require attention and assessment within 23 hours even though the enrollee is not an immediate danger to self or others and is able to cooperate in treatment.

Urgent Care — Services for conditions, which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain, etc.) or could substantially restrict an enrollee's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

Validation — The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Voluntary Enrollee — A Medicaid recipient who is not mandated to enroll in a Managed Care Plan, but chooses to do so.

Voluntary Potential Enrollee — A Medicaid recipient who is not mandated to enroll in a Managed Care Plan, has expressed a desire to do so, but is not yet enrolled in a Managed Care Plan.

Well Care Visit — A routine medical visit for one of the following: CHCUP visit, family planning, routine follow-up for a previously treated condition or illness, adult physicals or any other routine visit for other than the treatment of an illness.

ENROLLEE IDENTIFICATION (ID) CARD

Each enrollee will receive an ID card from Humana. If the enrollee loses his/her card, the enrollee may call Customer Service at 1-800-477-6931 to obtain a new one.

<p>Humana. Humana Medical Plan</p> <p>MEMBER NAME Member ID: HXXXXXXXXX</p> <p>Medicaid ID #: XXXXXXXX Group #: XXXXXXXX Date of Birth: XX/XX/XX RxBIN: 610649 Effective Date: XX/XX/XX RxPCN: 03190000</p> <p>PCP Name: XXXXXXXXX PCP Phone: (XXX) XXX-XXXX Primary Care Address: XXXXXXXXXXXX</p>	<p>Member/Provider Service: 1-800-477-6931</p> <p>Pharmacist Rx Inquiries: 1-800-865-8715 Pre-Certification and/or admission notification call: 1-800-523-0023 AHCA HMO Complaint Hotline: 1-888-419-3456</p> <p>Please mail all claims to: Humana Medical P.O. Box 14601 Lexington, KY 40512-4601</p>
<p>Humana. Humana Medical Plan</p> <p>MEMBER NAME Id. del afiliado: HXXXXXXXXX</p> <p>Id. de Medicaid: XXXXXXXX N.º de grupo: XXXXXXXX Fecha de nacimiento: XX/XX/XX RxBIN: 610649 Fecha de entrada en vigor: XX/XX/XX RxPCN: 03190000</p> <p>Nombre del PCP: XXXXXXXXX No. de teléfono del PCP: (XXX) XXX-XXXX Dirección de atención primaria: XXXXXXXXXXXX</p>	<p>Servicio para afiliados/proveedores: 1-800-477-6931</p> <p>Consultas sobre recetas de farmacéuticos: 1-800-865-8715 Precertificación y/o notificación de admisión llamar al: 1-800-523-0023 Línea directa de quejas para HMO de AHCA: 1-888-419-3456</p> <p>Por favor, envíe todas las reclamaciones por correo a: Humana Medical P.O. Box 14601 Lexington, KY 40512-4601</p>

COVERED SERVICES

GENERAL SERVICES

Humana, through its contracted providers, is required to arrange for the following medically necessary services for each patient:

Advanced Registered Nurse Practitioner Services	Hospital Services — Inpatient/Outpatient
Ambulatory Surgical Centers	Imaging Services
Assistive Care Services	Immunizations
Behavioral Health Services — Inpatient and Outpatient	Laboratory Services
Birth Center Services	Licensed Midwife Services
Child Health Checkup Services	Optometry
Chiropractic Services	Physician Assistant Services
Community Mental Health Services	Podiatric Services
County Health Department Services	Primary Care Services
Dental Services	Primary Care Case Management Services
Durable Medical Equipment and Medical Supplies	Prescribed Drug Services
Dialysis Services	Prostheses and Orthoses
Emergency Services	Renal Dialysis Services
Emergency Behavioral Health Services	Rural Health Clinic Services
Family Planning Services and Supplies	Specialty Provider Services
Federally Qualified Health Center Services	Targeted Case Management
Free-standing Dialysis Centers	Therapy Services
Healthy Start Services	Transplant Services
Hearing Services	Transportation Services
Home Health Services and Nursing Care	Vision Services
Hospice	X-ray Services, Including Portable X-rays

In providing covered services to Medicaid enrollees, the provider is required to adhere to applicable provisions in the Florida Medicaid Coverage and Limitations Handbook, as well all state and federal laws pertaining to the provision of such services.

OUT-OF-NETWORK CARE FOR SERVICES NOT AVAILABLE

Humana will arrange for out-of-network care if it is unable to provide members with necessary covered services or a second opinion, if a network health care provider is not available. Humana will coordinate payment with the out-of-network provider to confirm that any cost to the member is not greater than it would be if the service were provided in-network.

EXPANDED SERVICES

Expanded services are those services offered by Humana and approved in writing by the Agency.

Such expanded benefits are those services or benefits not otherwise covered or that exceed limits outlined in the in the Medicaid State Plan and the Florida Medicaid Coverage and Limitations Handbooks and the Florida Medicaid Fee Schedules. These services are in excess of the amount, duration and scope of those services listed above. In instances where an expanded benefit is also a Medicaid covered service, the Managed Care Plan shall administer the benefit in accordance with any applicable service standards pursuant to this Contract, the Florida Medicaid State Plan and any Medicaid Coverage and Limitations Handbooks. Humana Medicaid members have specific enhanced benefits. Please see the member handbook for benefit descriptions and details.

If copayments are waived as an expanded benefit, the provider must not charge enrollees copayments for covered services; and if copayments are not waived as an expanded benefit, that the amount paid to providers shall be the contracted amount or for FFS Managed Care Plans, the Medicaid fee schedule amount, less any applicable copayments.

EMERGENCY SERVICE RESPONSIBILITIES

Participating providers are required to ensure adequate accessibility for health care 24 hours per day, seven days per week. Enrollees should call their PCP first if they have an emergency, but go to the closest emergency room or any other emergency setting if they have an emergency like any of the following:

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

Enrollees are instructed to call their PCP as soon as possible when they are in a hospital or have received emergency care. When an enrollee presents at a hospital seeking emergency services and care, the determination that an emergency medical condition exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician. See ss. 409.9128, 409.901, F.S. and 641.513, F.S.

If the emergency room doctor treating the enrollee tells the enrollee that the visit is not an emergency, the enrollee will be given the choice to stay and get medical treatment or follow up with his/her primary care physician. If the enrollee decides to stay and receive treatment, then the services rendered will not be a covered benefit.

If the enrollee's PCP responds to the hospital's notification, and the hospital physician and the PCP discuss the appropriate care and treatment of the enrollee, the Managed Care Plan may have a member of the hospital staff with whom it has a participating provider contract participate in the treatment of the enrollee within the scope of the physician's hospital staff privileges.

If the enrollee is treated for an emergency and the treating doctor recommends treatment after the enrollee is stabilized, the enrollee is instructed to call his/her Humana PCP.

Enrollees who are away from home and have an emergency are instructed to go to the nearest emergency room or any emergency setting of their choice. In such situations, enrollees should call their PCP as soon as possible.

EMERGENCY BEHAVIORAL HEALTH SERVICES

For mental health services, enrollees should call the mental health care provider in their area. The provider can give the enrollee a list of common problems with behavior and talk to the enrollee about how to recognize the problems.

Members in Miami-Dade, Monroe, Broward, Palm Beach, Indian River, Martin, Okeechobee, St. Lucie, Hardee, Highlands, Hillsborough, Manatee and Polk counties may call Beacon Health Options at **1-800-221-5487**.

Members in Escambia, Okaloosa, Santa Rosa and Walton counties may call Lake View/Access Behavioral Health at **1-866-477-6725**.

Treatment for psychiatric and emotional disorders includes the following services:

- Counseling
- Evaluation and testing services
- Therapy and treatment services
- Pet therapy
- Art therapy
- Rehabilitation services
- Children's behavioral health care services
- Day treatment services

For emergency mental health care within or outside the service area, please instruct enrollees to go to the closest hospital emergency room or any other recommended emergency setting. They should contact you first if they are not sure the problem is an emergency.

Emergency mental health conditions include:

- Danger to themselves or others
- Unable to carry out actions of daily life due to so much functional harm
- Serious harm to the body that may cause death

In addition, the Plan and the mental health provider shall ensure:

1. The enrollee has a follow-up appointment within seven (7) days after discharge; and
2. All required prescriptions are authorized at the time of discharge.

It is agreed that the Humana Health Plan provider will do the following:

1. Provide a health screening evaluation that should consist of comprehensive health and developmental history, including assessment of past medical history, developmental history and behavioral health status; comprehensive unclothed physical examination; developmental assessment; nutritional assessment; appropriate immunizations according to the appropriate Recommended Childhood Immunization Schedule for the United States; laboratory testing (including blood lead testing); health education (including anticipatory guidance); dental screening (including a direct referral to a dentist for enrollees beginning at 3 years of age or earlier as

- indicated); vision screening, including objective testing as required; hearing screening, including objective testing as required; diagnosis and treatment; and referral and follow-up as appropriate.
2. For children/adolescents who the primary care provider identifies through blood lead screenings as having abnormal levels of lead, the primary care provider should provide case management follow-up services as required in chapter two (2) of the Child Health Checkup Services Coverage and Limitations Handbook. Screening for lead poisoning is a required component of health screening. Humana requires all providers to screen all enrolled children for lead poisoning at 12 and 24 months of age. In addition, children between the ages of 12 months and 72 months of age must receive a blood screening lead test if there is no record of a previous test. The primary care provider should provide additional diagnostic and treatment services determined to be medically necessary to a child diagnosed with an elevated blood lead level. The primary care provider should recommend, but not require, the use of paper filter tests as part of the lead screening requirement.
 3. The primary care provider should inform enrollees of all testing/screenings due in accordance with the periodicity schedule specified in the Medicaid Child Health Checkup Services Coverage and Limitations Handbook. The primary care provider should contact enrollees to encourage them to obtain health assessments and preventive care.
 4. The primary care provider should refer enrollees to appropriate service providers within four weeks of the examination for further assessment and treatment of conditions found during the examination.
 5. The primary care provider shall cover fluoride treatment for children/adolescents even if the Health Plan does not provide dental coverage. Fluoride varnish application in a physician's office is limited to children up to 3 ½ years (42 months) of age.
 6. The primary care provider should offer scheduling assistance and transportation to enrollees in order to assist them to keep, and travel to, medical appointments.
 7. The CHCUP program includes the maintenance of a coordinated system to follow the enrollee through the entire range of screening and treatment, as well as supplying CHCUP training to medical care providers.
 8. Pursuant to s. 409.975(5), F.S., Humana shall achieve a CHCUP screening rate of at least eighty percent (80%) for those enrollees who are continuously enrolled for at least eight (8) months during the federal fiscal year (October 1-September 30). This screening compliance rate is based on the CHCUP screening data reported by the primary care provider and due to the Agency by January 15 following the end of each federal fiscal year. The data should be monitored by the Agency for accuracy, and, if the primary care provider does not achieve the 60 percent screening rate for the federal fiscal year reported, the primary care provider should file a corrective action plan (CAP) with the Agency no later than February 15, following the fiscal year reported. Any datum reported by the primary care provider found to be inaccurate should be disallowed by the Agency, and the Agency should consider such findings as being in violation of the Contract and may sanction the primary care provider accordingly.
 9. Humana will adopt annual screening and participation goals to achieve at least an 80 percent CHCUP screening and participation rate. For each federal fiscal year that the Humana Provider Network does not meet the 80 percent screening and participation rate, Humana must file a CAP with the Agency no later than February 15, following the federal fiscal year being reported.

CHILD HEALTH CHECKUP

PRESCRIBING PSYCHOTROPIC MEDICATION TO A CHILD

Florida statute requires that providers have express and informed consent from a child's parent or legal guardian for the prescription of a psychotropic (psychotherapeutic) medication to a child in the Medicaid program. The provider needs to document the consent in the child's medical record and provide the pharmacy with a signed attestation of this documentation with the prescription. A "child" means a person from birth until the person's 13th birthday.

The attestation must be completed and presented to the pharmacy with every new prescription. The word "new" refers to every time a new prescription number is assigned, and includes all new prescriptions, including same drug/same dose prescriptions for continuing therapy. It does not replace prior authorization requirements for medications not included on the preferred drug list (PDL) or prior authorized antipsychotics for the children and adolescents birth through 17 years of age.

Prescriptions may be phoned in or emailed for these medications when the child is younger than 13. The pharmacist should obtain a completed consent form from the prescriber via fax, mail or from the guardian prior to dispensing.

Psychotropic medications include antipsychotics, antidepressants, antianxiety medications and mood stabilizers. Anticonvulsants and attention-deficit hyperactivity disorder (ADHD) medications (stimulants and nonstimulants) are not included at this time.

For additional information, including a list of generic names of medications subject to the informed consent and a link to a variety of consent forms allowed, please visit http://ahca.myflorida.com/medicaid/Prescribed_Drug/banners.shtml.

CHILD HEALTH CHECKUP

A child health checkup is a regularly scheduled comprehensive, preventive health screening service for children from birth through age 20. Child health checkups are performed according to a periodic schedule to help children have a routine health screening to identify and correct medical conditions before the conditions become more serious and potentially disabling. Child Health Checkup (CHCUP) is Florida's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

What are the components of the child health checkup?

A child health checkup is composed of the following:

- Comprehensive health and developmental history, including assessment of past medical history, developmental history and behavioral health status
- Nutritional assessment

- Developmental assessment
- Comprehensive unclothed physical examination
- Dental screening, including dental referral, when required
- Vision screening, including objective testing, when required
- Hearing screening, including objective testing, when required
- Laboratory test, including blood lead testing, when required
- Appropriate immunizations
- Health education, anticipatory guidance
- Diagnosis and treatment
- Referral and follow-up, as appropriate

Please refer to the following Child Health Checkup information and screening codes:

The procedure codes for a Child Health Checkup service are the Current Procedural Terminology (CPT) Preventive Medicine Services Codes. In some cases, one or two modifiers are required to uniquely identify the service provided. Both the procedure code and modifiers listed must be completed on the claim in order to receive proper reimbursement. No modifiers other than the ones listed in this chapter are allowed with billing these services.

Humana must ensure that its Managed Medicaid members receive these checkups, so confirming that they are billed correctly is critical. **Please note: Providers can bill a sick visit in addition to the Child Health Checkup and receive reimbursement for both.**

Child health checkup age or description	Well-child ICD-9 codes	New patient codes	Established patient codes
Neonatal exam	NA	99460, 99461, 99463	NA
Two to four days for newborns discharged less than 48 hours after delivery	NA		
By 1 month	NA	99381	99391
2 months	NA		
4 months	NA		
6 months	NA		
9 months	NA		
12 months	NA	99382	99392
15 months	NA		
18 months	NA		
2 years to 4 years	NA		
5 years to 11 years	NA	99383	99393
12 years to 17 years	NA	99384	99394
18 years to 20 years	NA	99385 EP	99395 EP
Routine child health check	V20.2	99202 – 99205	99213 – 99215
Routine general medical exam	V70.0		

Child health checkup age or description	Well-child ICD-9 codes	New patient codes	Established patient codes
Other medical exam for administrative purpose	V70.3		
Health exam of defined subpopulation	V70.5		
Health exam in population survey	V70.6		
Other specified general medical exam	V70.8		
Unspecified general medical exam	V70.9		

ICD-9 codes were replaced by the following ICD-10 codes effective Oct. 1, 2015*:

- Z76.2 (Encounter for health supervision and care of other healthy infant and child)
- Z00.121 (Encounter for routine child health examination with abnormal findings)
- Z00.129 (Encounter for routine child health examination without abnormal findings)
- Z00.110 (Health examination for newborn under 8 days old)
- Z00.111 (Health examination for newborn 8 to 28 days old)
- Z00.00-01 (Encounter for general adult medical examination without/with abnormal findings)
- Z02.0 (Encounter for examination for admission to educational institution)
- Z02.1 (Encounter for pre-employment examination)
- Z02.2 (Encounter for examination for admission to residential institution)
- Z02.3 (Encounter for examination for recruitment to armed forces)
- Z02.4 (Encounter for examination for driving license)
- Z02.5 (Encounter for examination for participation in sport)
- Z02.6 (Encounter for examination for insurance purposes)
- Z02.81 (Encounter for paternity testing)
- Z02.82 (Encounter for adoption services)
- Z02.83 (Encounter for blood-alcohol and blood-drug test)
- Z02.89 (Encounter for other administrative examinations)
- Z00.8 (Encounter for other general examination)
- Z00.6 (Encounter for examination for normal comparison and control in clinical research program)
- Z00.5 (Encounter for examination of potential donor of organ and tissue)
- Z00.70 (Encounter for examination for period of delayed growth in childhood without abnormal findings)
- Z00.71 (Encounter for examination for period of delayed growth in childhood with abnormal findings)

* This information is current as of October 2015. CPT code billing is subject to change. Please reference the Florida Medicaid Provider General Handbook for updates.

CHILD BLOOD LEAD SCREENINGS

Federal regulations also require that children receive a blood screening for lead test at 12 months old and at 24 months old. Children aged 36 to 72 months who have not previously been screened also should be screened for lead poisoning. Humana recommends that health care providers use a verbal lead-screening questionnaire to assess the risk of elevated levels in children 6 months to 6 years old. Taking Centers for Disease Control and Prevention (CDC) guidelines and recommendations into account, children whose blood lead levels are found to be 10 mcg/dL or greater (by venous sampling) should be treated and managed according to the physician's discretion. Follow-up visits should include identification of possible sources of lead, appropriate treatment and periodic repeat testing.

Importance of lead testing:

Federal regulation requires that all children receive a blood test for lead at:

- 12 months old and 24 months old
- 36 months and 72 months old for children who have not had a previous blood lead screening.

PROVIDER COMPLAINTS

For all inquiries, including complaints, please contact Humana customer service at **1-800-477-6931** or your provider contracting representative. Based on the type of issue or complaint, your inquiry will be reviewed by a Humana associate with the designated authority to resolve your issue or complaint.

GRIEVANCE SYSTEM

The section below is taken from Humana’s Enrollee Grievance and Appeal procedure as set forth in the Humana Member Handbook. This information is provided to you so that you may assist Humana enrollees in this process, should they request your assistance. Please contact your provider contracting representative should you have questions about this process.

Humana has representatives who handle all enrollee 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 an enrollee has questions or an issue, he or she may call Humana Customer Service at **1-800-477-6931** between 8 a.m. – 8 p.m.

If an enrollee is not happy with the answer he or she receives from customer service, an enrollee can file a grievance/appeal.

An enrollee can call customer service to file a complaint, grievance or an appeal. If an enrollee calls about a complaint and we are unable to resolve the complaint by the close of business the following day, then we will automatically send it to our grievance process. If an enrollee would like to file a complaint, grievance or appeal in writing, the enrollee may send us a letter or he or she can get a form from our website or by calling customer service. If an enrollee asks for a form from Humana, it will be mailed within three working days. An enrollee can also request help from Humana to fill out the form.

All grievance/appeals will be considered. The enrollee can have someone help during the process, whether it is a provider or someone he or she chooses.

The enrollee has the right to continue services during the grievance/appeal process. If the enrollee would like his/her services to continue, the enrollee must submit an appeal within 10 business days after the notice of action is mailed; or within 10 business days after the intended effective date of action, whichever is later. However, if the decision of the Grievance/Appeal Committee is not in the enrollee’s favor, the enrollee 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 actions were taken to correct the issue
- What action would resolve the grievance/appeal
- Signature
- Date

Grievance: The enrollee has 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 the enrollee's grievance as quickly as his or her health condition requires. A letter telling the enrollee the outcome of the grievance will go out within 90 days from the date Humana receives the request. The enrollee can request a 14-day extension if needed. We can also request an extension if additional information is needed and is in the enrollee's best interest. Humana will send the enrollee a letter telling him or her about the extra time, what additional information is needed and why it is in the enrollee's best interest.

Appeal: An enrollee must file the appeal either verbally or in writing within 30 calendar days of the receipt of the notice of action, and except when expedited resolution is required, must be followed with a written notice within ten (10) calendar days of the oral filing. The date of the oral notice will be considered the date of receipt. An enrollee has 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 the appeal as quickly as the health condition requires. A letter telling the enrollee the outcome of the appeal will go out within 45 days from the date Humana receives the request. The enrollee can request a 14-day extension if needed. We can also request an extension if additional information is needed and is in the enrollee's best interest. Humana will inform the enrollee by mail of any extra time needed to make a decision, what additional information is needed and why it is in the enrollee's best interest.

Expedited Process: The enrollee has the right to make an expedited verbal or written grievance or appeal. If there is a problem that is putting the enrollee's life or health in danger, the enrollee or the enrollee's legal spokesperson can file an "urgent" or "expedited" appeal. These appeals are handled within 72 hours. When making an appeal, the enrollee or enrollee's legal spokesperson needs to let Humana know that this is an "urgent" or "expedited" appeal. An expedited appeal may be made by calling Humana at 1-888-259-6779. If it is determined that it is not an expedited process, it will go through the normal process.

Medicaid Fair Hearing: If an enrollee is not happy with Humana's grievance or appeal decision, he or she can ask for a Medicaid Fair Hearing.

An enrollee may seek a Medicaid Fair Hearing without having first exhausted the Humana's grievance and appeal process.

An enrollee who chooses to exhaust the Humana's grievance and appeal process may still file for a Medicaid Fair Hearing within ninety (90) calendar days of receipt of the Humana's notice of resolution.

An enrollee who chooses to seek a Medicaid Fair Hearing without pursuing Humana's process must do so within ninety (90) days of receipt of the notice of action. Parties to the Medicaid Fair Hearing include the Plan as well as the enrollee, or that person's authorized representative.

The addresses and phone numbers for Medicaid Fair Hearings at the local Medicaid Area Offices can be found at:

https://portal.flmmis.com/FLPublic/Provider_ContactUs/tabId/38/Default.aspx

They are as follows:

Department of Children and Families

Office of Appeal Hearings Building 5, Room 255
1317 Winewood Blvd.
Tallahassee, FL 32399-0700

1-850-488-1429

1-850-487-0662 (fax)

Appeal_Hearings@dcf.state.fl.us (email)

<http://www.myflfamilies.com/about-us/office-inspector-general/investigation-reports/appeal-hearings>

The enrollee has the right to continue to receive benefits during a Medicaid Fair Hearing. He or she can request to continue to receive benefits by calling our customer service department at **1-800-477-6931** between 8 a.m. and 8 p.m. If the decision is not in the enrollee's favor, he or she may have to pay for those benefits. The enrollee has the right to review his or her case before and during the appeal process.

Beneficiary Assistance Program: If the enrollee is not satisfied with Humana's appeal or grievance decision, he or she can ask for a review by the Beneficiary Assistance Program (BAP). The enrollee has one year from receipt of the decision letter to request this review. If the member has already had a review completed by the Medicaid Fair Hearing, the BAP will not consider the appeal.

To request this review, the enrollee may contact: Agency for Health Care Administration, Beneficiary Assistance Program, Building 3, MS 26, 2727 Mahan Drive, Tallahassee, Florida 32308, or call **1-850-412-4502**, or toll free **1-888-419-3456**.

To send the grievance or appeal request in writing, the enrollee may mail it to the following address:

South Florida Humana Humana Medical Plan Inc.
P.O. Box 14546
Lexington, KY 40512-4546
Attn: Medicaid Grievance & Appeal Analyst

Office hours for the grievance and appeals review department are from 8 a.m. – 8 p.m. Eastern time, Monday – Friday. If the enrollee cannot hear or has trouble talking, he or she may call 711.

If the enrollee wishes to walk in and file a grievance and appeal, the enrollee may do so at the following address:

Humana Medical Plan Inc.
3501 SW 160th Ave.
Miramar, FL 33027

Office hours are Monday – Friday from 9 a.m. – 5 p.m. Eastern time.

If the enrollee wishes to contact our customer service department by phone, he or she may call **1-800-477-6931**.

If the enrollee cannot hear or has trouble talking, he or she may call **1-800-833-3301**. Customer service department hours are Monday – Friday, 8 a.m. – 8 p.m. Eastern time.

If the enrollee is calling after-hours, weekends or holidays for an urgent/expedited grievance or appeal, he or she will be asked to leave a voicemail and he or she will receive a callback by the end of the following day by a specialized team to address the expedited grievance or appeal.

CHRONIC AND COMPLEX CONDITIONS

COMPREHENSIVE DIABETES CARE

Diabetic Retinal Examinations: Humana is committed to reducing the incidence of diabetes-induced blindness in Humana enrollees. Early intervention and continual monitoring of diabetic eye disease could reduce the incidence of diabetes-related blindness. Based on guidelines proposed by the American College of Physicians, the American Diabetic Association and the American Academy of Ophthalmology, the Humana primary care provider will provide or manage services such that recipients with a history of diabetes will receive at least one fundoscopic exam every 12 months.

Glycohemoglobin Levels: Humana acknowledges that tight control of blood glucose levels can delay the onset and slow the progression of many of the side effects from diabetes. Glycohemoglobin is one laboratory indicator of how well an enrollee's blood sugar is controlled. Consistent with the American Diabetic Association recommendations, the Humana primary care provider will provide or manage services such that enrollees with a history of diabetes will receive glycohemoglobin determinations at least twice a year.

Lipid Levels: Humana recognizes the direct link between hyperlipidemia, secondary hyperlipoproteinemias and diabetes mellitus. By closely monitoring lipids and lipoprotein levels in diabetics, better control and maintenance of diabetes is possible. Consistent with the recommendations of the American Diabetes Association, the Humana primary care provider will provide or manage services such that enrollees with a history of diabetes will receive lipid and lipoprotein determination annually. If anomalies are found in the annual baseline, additional studies should be conducted as medically necessary.

NEPHROPATHY

The Humana primary care provider screening for nephropathy is to delay or prevent loss of renal function through early detection and initiation of effective therapies, and to manage complications in those identified with a renal disease. The primary care provider will manage the enrollee by identifying evidence of a positive test for protein in the urine (microalbuminuria testing). Enrollee is to be monitored for the disease, including end-stage renal, chronic renal failure, renal insufficiency or acute renal failure, and referred to a nephrologist as deemed medically appropriate.

CONGESTIVE HEART FAILURE

Humana is aware there are effective options for treating heart failure and its symptoms. Humana recognizes that with early detection symptoms can be reduced, and many heart failure patients are able to resume normal active lives. To further these goals, the Humana primary care provider will provide or

manage care of the CHF enrollee by prescribing and monitoring an ace inhibitor, angiotensin II receptor blockers (ARB) and diuretic and reviewing the contraindications of those medications prescribed. An echocardiogram should be performed annually, and the enrollee should be instructed on nutrition and education ongoing of his or her disease.

ASTHMA

Humana recognizes that asthma is a common chronic condition that affects children and adults. The primary care provider will be expected to measure the enrollee's lung function and assess the severity of asthma and to monitor the course of therapy based on the following:

1. Educate the enrollee about the contributing environmental control measures to avoid or eliminate factors that precipitate asthma symptoms or exacerbations.
2. Introduce comprehensive pharmacologic therapy for long-term management designed to reverse and prevent the airway inflammation characteristic of asthma as well as pharmacologic therapy to manage asthma exacerbations.
3. Facilitate education that fosters a partnership among the enrollee, his or her family and clinicians.

HYPERTENSION

Humana recognizes that primary care providers can assist the enrollees by checking blood pressure at every opportunity and by counseling enrollees and their families about preventing hypertension. Enrollees would benefit from general advice on healthy lifestyle habits, in particular healthy body weight, moderate consumption of alcohol and regular exercise. The primary care provider is expected to document in each enrollee's medical record the confirmation of hypertension and identify if the enrollee is at risk for hypertension.

HIV/AIDS

Humana requires that primary care providers assist enrollees in obtaining necessary care in coordination with Humana Health Services staff. Please contact health services at 1-800-322-2758, ext. 102-4484, or your provider contract representative for more details.

TUBERCULOSIS

Humana shall be responsible for the care for enrollees who have been diagnosed with tuberculosis disease, or show symptoms of having tuberculosis and have been designated a threat to the public health by the Florida Department of Health (FDOH) Tuberculosis Program and shall observe the following:

1. Said enrollees shall be hospitalized and treated in a hospital licensed under Chapter 395 F.S. and under contract with the FDOH pursuant to 392.62, Florida Statutes;
2. Treatment plans and discharge determinations shall be made solely by FDOH and the treating hospital;

3. For enrollees determined to be a threat to public health and receiving tuberculosis treatment at an FDOH contracted hospital, the Managed Care Plan shall pay the Medicaid per diem rate for hospitalization and treatment as negotiated between Florida Medicaid and FDOH, and shall also pay any wrap-around costs not included in the per diem rate; and
4. Reimbursement shall not be denied for failure to prior authorize admission, or for services rendered pursuant to 392.62 F.S.

TELEPHONIC MEDICAID DISEASE MANAGEMENT PROGRAM

The goals of the Medicaid disease management program provided by Humana:

- Improve members' understanding and assist self-management of their disease with education and support while following their doctor's plan of care
- Help members maintain optimal disease management and mitigate potential comorbidities using interventions to influence behavioral changes
- Increase member compliance and disease-specific knowledge with plan of care via mailed materials, recommended websites and newsletters
- Ensure timely medical/psychological visits and appropriate utilization of access to care to include the use of home health care services
- Find and obtain community-based resources that meet the member's medical, psychological and social needs
- Develop routine reporting and feedback loops that may include communications with patients, physicians, health plan and ancillary providers via telephonic contact and secure fax progress notes
- Provide proactive health promotion education to increase awareness of the health risks associated with certain personal behaviors and lifestyles
- Evaluate clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall population health of disease management program members

Disease management case managers with a nursing license are selected based on demonstrated skills in classifying, assessing, monitoring, evaluating, instructing, intervening and documenting goals and outcomes of members with:

- Diabetes
- Congestive heart failure
- Hypertension
- HIV+/AIDS
- Adult/Pediatric asthma

Member eligibility is based on a member having one or more of the above diagnoses. The disease management program provides services that include, but are not limited to:

- Evaluating member needs that can affect control of their disease such as physical limitations, mental health effects, transportation difficulties and environmental needs
- Developing self-management goals and plan of care considering members' health history, psychosocial assessment, providers' plan of care and members' needs

- Educating on diagnosis and potential treatment modalities
- Referring to internal and external programs
- Supporting members and providers regarding diagnosis, plan of care and other health-related concerns
- Educating and assisting members on reaching disease-specific diet and exercise goals
- Educating members on recommended health checks

The member may contact the primary care physician to request a disease management program referral or may call Humana at 1-800-322-2758 for a self-referral.

Referrals are also generated by claims data, on-site and telephonic nurses after discharge, PCPs, internal and external programs and community partners.

To obtain more information about the program, refer a member, provide feedback or file a complaint for disease management, please call 1-800-322-2758. Hours of operation are Monday – Friday, 8:30 a.m. – 5 p.m. Eastern time, or navigate to **Humana.com**. Enrollment or disenrollment from this program is voluntary.

Complex Case Management: Complex case management is a service provided to Medicaid members by Humana nurses specially trained in case management. Their specialized focus is on members with complex medical needs. Management is designed to meet the medical and psychosocial needs of the member and varies depending on situation and severity. A multidisciplinary team approach is utilized to ensure the member's needs are met and all efforts are made to improve and optimize his/her overall health and well-being. A team of physicians, social workers and community services partners are on hand to help make sure members' needs are met and all efforts are made to improve and optimize their overall health and well-being. The case management program is optional. To refer Medicaid members and verify program eligibility, please call the health services department at 1-800-322-2758.

Quality Improvement (QI) Program: Humana's quality improvement program includes clinical care, preventive care and member services. View Humana's Quality Improvement Progress Report for information about our quality improvement program and progress toward our goals on the provider website: http://www.humana.com/providers/clinical/quality_resources.aspx. Health care providers may also obtain a written quality improvement (QI) program description by calling 1-800-4-HUMANA (1-800-448-6262).

We welcome health care providers' input regarding our QI Program. Feedback can be provided in writing to the following address:

Humana Quality Management Department
321 W. Main St., WFP 20
Louisville, KY 40202

Utilization Management (UM): Humana wants to ensure its members receive the right medical care from the right provider at the right time. Humana works with practitioners and providers to deliver services that are correct and medically needed for a member's medical condition.

- UM decision making at Humana is based only on appropriateness of care and service and existence of coverage.
- Humana does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

If you have questions or concerns related to utilization management, staff is available Monday – Friday from 8:30 a.m. – 5 p.m. Eastern time, by calling 1-800-322-2758.

Humana has people and free language interpreter services available to answer questions related to utilization management from non-English speaking members. TTY users should call 711.

PCP AND OTHER PROVIDER/SUBCONTRACTOR RESPONSIBILITIES

ACCESS TO CARE

Participating primary care providers are required to ensure adequate accessibility for health care 24 hours per day, seven days per week. An after-hours telephone number must be available to members (voice mail is not permitted). The enrollee should have access to care for PCP services and referrals to specialists for medical and behavioral health services available on a timely basis, as follows:

- Urgent Care: Enrollee must be seen within one (1) day of the request.
- Sick Care: Enrollee must be seen within one (1) week of requesting an appointment.
- Well-care Visit: Enrollee must be seen within one (1) month of requesting an appointment.

AMERICANS WITH DISABILITIES ACT (ADA)

All Humana-contracted health care providers must comply with the Americans with Disabilities Act (ADA), as well as all applicable state and/or federal laws, rules and regulations. More details are available in the Humana provider agreement under “Compliance with Regulatory Requirements.”

Humana develops individualized care plans that take into account members’ special and unique needs. Health care providers with patients who require interpretive services may contact their provider relations representative with questions.

If you have members who need interpretation services, they can call the number on the back of their member ID cards or visit Humana’s website at: <https://www.humana.com/accessibility-resources>.

TRANSITION/COORDINATION OF CARE OF NEW ENROLLEES

There will be coordination of care for new enrollees transitioning into the Managed Care Plan. In the event a new enrollee is receiving a prior-authorized ongoing course of treatment with any provider, the Managed Care Plan shall be responsible for the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or nonparticipating providers. Providers shall be reimbursed at the rate they received for services immediately prior to the enrollee transitioning for a minimum of thirty (30) days.

Humana shall provide continuation of MMA services until the enrollee’s PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the enrollee’s treatment plan, which shall be no more than sixty (60) calendar days after the effective date of enrollment. Providers should continue providing services to enrollees during the 60-day continuity of care period for any services that were previously authorized or prescheduled prior to the implementation, regardless of whether the provider is participating in Humana’s network.

Providers should keep previously scheduled appointments with new enrollees during the transition.

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

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

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

- Prior existing orders
- Provider appointments (e.g., dental appointments, surgeries, etc)
- Prescriptions (including prescriptions at nonparticipating pharmacies)
- Behavioral health services

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

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

- Continue Care Plan as is for up to 60 days
- Ensure there are no care disruptions
- Emphasize the member's comfort and safety while addressing unmet needs
- Contract with nonparticipating providers
- Reassess and update the personalized plan of care
- Identify members who desire to transition/continuity of care
- Determine unmet needs and put necessary services in place
- Coordinate and build relationships with providers
- Put the enrollee with a new case manager
- Identify members who desire to transition/continuity of care
- Determine unmet needs and put necessary services in place
- Coordinate and build relationships with providers

FAMILY PLANNING SERVICES

The Agency for Health Care Administration (AHCA) requires that Medicaid enrollees under the age of 18 receive family planning services provided the enrollee is married, a parent, pregnant, has written consent from a parent or legal guardian or, in the opinion of a physician, the enrollee may suffer health hazards if the services are not provided.

Family Planning Services and Supplies:

- The Managed Care Plan shall provide family planning services to help enrollees make comprehensive and informed decisions about family size and/or spacing of births. The Managed

Care Plan shall provide the following services: planning and referral, education and counseling, initial examination, diagnostic procedures and routine laboratory studies, contraceptive drugs and supplies, and follow-up care in accordance with the Medicaid Practitioner Services Coverage and Limitations Handbook.

- This information should be documented in the patient’s medical record to meet the contractual requirement. Humana or AHCA may audit your medical records to confirm compliance with this contractual clause.
- Members can choose from any Medicaid doctor for family planning services. Prior approval is not needed.

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

IMMUNIZATIONS

Immunizations should be provided in accordance with the Recommended Childhood Immunization Schedule for the United States or when medically necessary for the enrollee’s health, as determined by the physician. Providers should participate in the Vaccines for Children program (VFC) as described in Section 1905(c)(1) of the Social Security Act and administered by the Department of Health, Bureau of Immunizations. The VFC provides vaccines at no charge to physicians and eliminates the need to refer children to County Health Departments (CHDs) for immunizations. Title XXI MediKids enrollees do not qualify for the VFC program and must be billed through Medicaid fee-for-service directly for immunizations provided to Title XXI MediKids participants.

Please note: Immunizations should be provided in accordance with the Recommended Childhood Immunization Schedule for the United States or when medically necessary for the enrollee’s health, as determined by the physician.

ADULT HEALTH SCREENING

Adult Preventive Health Exam – Beginning at age 21

Elements:

1. Risk Screening
2. Interval History

Guidelines:

Screening to identify high-risk individuals, assessing family medical and social history is required. Screening for the following risks are to be included as a minimum: cardiovascular disease, hepatitis, HIV/AIDS, STDs and TB.

Interval histories are required with preventive health care.

Changes in medical, emotional and social status are to be documented.

3. Immunizations

Immunizations are to be documented and current.

If immunization status is not current, this is to be documented with a catch-up plan. Immunizations are required as follows: influenza, annually beginning at age 65 years, Td booster every 10 years; pneumococcal vaccine beginning at age 65. When an individual has received a pneumococcal vaccination prior to the age of 65 years and it has been five years since the vaccination, the individual should be revaccinated.
4. Height and Weight

Documented height and weight is required for all preventive health care visits and at least:

 - every five years for ages 21-40
 - every two years beginning at age 41
5. Vital Signs

Pulse and blood pressure are required for all preventive health care visits and at least:

 - every five years for ages 21-40
 - every two years beginning at age 41
6. Physical Exam

Appropriate evaluation for inclusion in the baseline physical examination of an asymptomatic adult are:

 - general appearance
 - skin
 - gums/dental/oral
 - eyes/ears/nose/throat
 - neck/thyroid
 - chest/lungs
 - cardiovascular
 - breasts
 - abdomen/GI
 - genital/urinary
 - musculoskeletal
 - neurological
 - lymphatic

If noncompliance or refusal is documented, the risk associated with the noncompliance must be documented.

7. Cholesterol Screening	<p>Screening required every five years for:</p> <ul style="list-style-type: none"> – Men, beginning age 35 – Women, beginning age 45 <p>(Earlier if there is any risk factor evident for cardiovascular disease)</p>
8. Visual Acuity Testing	<p>Visual acuity testing, at a minimum, is to document the patient's ability to see at 20 feet. Referrals for testing must be documented.</p>
9. Hearing Screening	<p>Test or inquire about hearing periodically/once a year.</p>
10. Electrocardiogram	<p>Periodically after age 40 to 50 (or as primary care deems medically appropriate).</p>
11. Colorectal Cancer	<p>Colorectal cancer screening must be documented beginning at age 50.</p> <p>Risk Factors: First-degree relatives or personal history of colorectal cancer, personal history of female genital or breast cancer, familial adenomatous polyposis, Gardner syndrome, hereditary nonpolyposis colon cancer, chronic inflammatory bowel disease.</p>
12. Pap Smear	<p>Baseline pap smears are required annually for three consecutive years until three consecutive normal exams are obtained; then every two to three years. May stop at age 65 if patient had regularly normal smears up to that age.</p>
13. Mammography	<p>Required as appropriate between ages 35 and 40:</p> <ul style="list-style-type: none"> – Every one to two years for women age 40 or older. – Earlier and/or more frequent for women at high risk.
14. Prostate Exam/Screening	<p>U.S. Preventive Services Task Force, December 2002:</p> <p>Evidence is insufficient to recommend for or against routine screening for prostate cancer using PSA testing or digital rectal examination. The USPSTF found evidence that PSA can detect early-stage prostate cancer but mixed and inconclusive evidence that would suggest early</p>

detection improves health outcomes. There was insufficient evidence to determine whether the benefits outweigh the harms (of biopsies, complications and anxiety), especially in a cancer that may have never affected the patient's health.

American College of Physicians 2004:

Recommendations are for selected testing in 50 to 69-year-olds provided that the risks, benefits and uncertainties are understood. Current available evidence suggests it is difficult to justify routine screening of men 70 and older.

15. Education/Anticipatory Guidance Health education and guidance must be documented.

Educational needs are based on risk factors identified through personal and family medical history and social and cultural history and current practices.

16. Osteoporosis

Screening for women age 65 and older is required; begin at age 60 if at increased risk for osteoporotic fractures. Perform DEXA scan for serial monitoring every two years; special conditions may need more frequent monitoring. All perimenopausal women should have a DEXA scan after a fracture, if test has not been performed recently.

HYSTERECTOMIES, STERILIZATIONS AND ABORTIONS

Participating providers must maintain a log of all hysterectomy, sterilization and abortion procedures performed on enrollees. The log must include, at a minimum, the enrollee's name and identifying information, date of procedure and type of procedure. The participating provider should provide abortions only in the following situations:

- If the pregnancy is a result of an act of rape or incest; or
- The physician certifies that the woman is in danger of death unless an abortion is performed.

HEALTHY START SERVICES

Providers treating enrollees who are pregnant should offer Florida's Health Start prenatal risk screening to each pregnant enrollee as part of her first prenatal visit. Providers conducting such screening must use the Department of Health (DOH) prenatal risk form (DH Form 3134), which can be obtained from the

local county health department (CHD). One copy of the completed screening form should be kept in the enrollee's medical record, and another copy should be provided to the enrollee. Within 10 business days from completion, the provider must submit the screening form to the CHD in the county in which the prenatal screen was completed.

Providers should also complete the Florida HealthyStart Infant Postnatal Risk Screening Instrument (DH Form 3135) with the Certificate of Live Birth and transmit both documents to the CHD in the county in which the infant was born within five business days from completion. Copies of Form 3135 should be maintained by the provider, included in the enrollee's medical record and furnished to the enrollee.

The provider shall notify the health plan immediately of an enrollee's pregnancy, which can be identified through medical history, examination, testing, claims or otherwise.

Pregnant enrollees or infants who do not score high enough to be eligible for HealthyStart care coordination may be referred for services, regardless of their score on the HealthyStart risk screen, in the following ways:

1. If the referral is to be made at the same time the HealthyStart risk screen is administered, the provider may indicate on the risk screening form that the enrollee or infant is invited to participate based on factors other than score; or
2. If the determination is made subsequent to risk screening, the provider may refer the enrollee or infant directly to the HealthyStart care coordinator based on assessment of actual or potential factors associated with high risk, such as HIV, hepatitis, hepatitis B, substance abuse or domestic violence.

Humana should refer all pregnant women, breast-feeding and postpartum women, infants and children up to age 5 to the local WIC office:

1. The participating provider of Humana should provide:
 - a. A completed Florida WIC program medical referral form with the current height or length and weight (taken within 60 calendar days of the WIC appointment);
 - b. Hemoglobin or hematocrit test results; and
 - c. Documentation of any identified medical/nutritional problem.
2. For subsequent WIC certifications, providers should coordinate with the local WIC office to provide the above referral data from the most recent CHCUP.
3. Each time the participating provider completes a WIC referral form, the provider should give a copy of the WIC referral form to the enrollee and retain a copy in the enrollee's medical record.

Providers must provide all women of childbearing age HIV counseling and offer them HIV testing. ⁽¹⁴⁾

1. In accordance with Florida law, providers should offer all pregnant women counseling and HIV testing at the initial prenatal care visit and again at 28 and 32 weeks.
2. Providers must attempt to obtain a signed objection if a pregnant woman declines an HIV test. ⁽¹⁶⁾
3. All pregnant women who are infected with HIV should be counseled about and offered the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services. ⁽¹⁷⁾

(14) Chapters 381, F.S., 2004.

(16) Sections 384.31, F.S., 2004 and 64D-3.019, F.A.C., 2004.

(17) U.S. Department of Health & Human Services, Public Health Service Task Force report entitled "Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States."

Providers must screen all pregnant enrollees receiving prenatal care for the hepatitis B surface antigen (HBsAg) during the first prenatal visit.

1. Providers must perform a second HBsAg test between 28 and 32 weeks of pregnancy for all pregnant enrollees who tested negative at the first prenatal visit and are considered high-risk for hepatitis B infection. This test should be performed at the same time that other routine prenatal screening is ordered.
2. All HBsAg-positive women should be reported to the local CHD and to Healthy Start, regardless of their Healthy Start screening score.

Participating providers should ensure that infants born to HBsAg-positive enrollees should receive hepatitis B immune globulin (HBIG) and the hepatitis B vaccine once they are physiologically stable, preferably within 12 hours of birth, and should complete the hepatitis B vaccine series according to the recommended vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States.

1. Providers should test infants born to HBsAg-positive enrollees for HBsAg and hepatitis B surface antibodies (anti-HBs) six months after the completion of the vaccine series to monitor the success or failure of the therapy.
2. Providers must report to the local CHD a positive HBsAg result in any child age 24 months or less within 24 hours of receipt of the positive test results.
3. Participating providers should ensure that infants born to enrollees who are HBsAg-positive are referred to Healthy Start, regardless of their Healthy Start screening score.

Participating providers should report to the perinatal hepatitis B prevention coordinator at the local CHD all prenatal or postpartum enrollees who test HBsAg-positive. Participating providers should also report said enrollees' infants and contacts to the perinatal hepatitis B prevention coordinator at the local CHD.

1. The participating provider should report the following information: name, date of birth, race, ethnicity, address, infants, contacts, laboratory test performed, date the sample was collected, the due date or estimated date of conception (EDC), whether or not the enrollee received prenatal care and immunization dates for infants and contacts.

2. The participating provider should use the perinatal hepatitis B Case and Contact Report (DH Form 2136) for reporting purposes.

PCPs must maintain all documentation of Healthy Start screenings, assessments, findings and referrals in the enrollees' medical records.

Participating providers should provide the most appropriate and highest level of quality care for pregnant enrollees, including, but not limited to, the following:

1. Prenatal Care — Participating providers of Humana, are expected to:
 - a. Require a pregnancy test and a nursing assessment with referrals to a physician, physician assistant (PA) or advanced registered nurse practitioner (ARNP) for comprehensive evaluation;
 - b. Require case management through the gestational period according to the needs of the enrollee;
 - c. Require necessary referrals and follow-up;
 - d. Schedule return prenatal visits at least every four weeks until the 32nd week, every two weeks until the 36th week, and every week thereafter until delivery unless the enrollee's condition requires more frequent visits;
 - e. Contact those enrollees who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care;
 - f. Assist enrollees in making delivery arrangements, if necessary; and
 - g. Ensure that all pregnant enrollees are screened for tobacco use and make available to the pregnant enrollees smoking cessation counseling and appropriate treatment as needed.
2. Nutritional Assessment/Counseling — Participating providers should supply nutritional assessment and counseling to all pregnant enrollees. In addition, participating providers of Humana are expected to:
 - a. Ensure the provision of safe and adequate nutrition for infants by promoting breastfeeding and the use of breast milk substitutes;
 - b. Offer a mid-level nutrition assessment;
 - c. Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or physician following the nutrition assessment; and
 - d. Document the nutrition care plan in the medical record by the person providing counseling.

Humana has partnered with Healthy Start. The Healthy Start program includes targeted support services that address identified risks. The range of free and voluntary Healthy Start services available to pregnant women, infants and children up to age 3 include:

- Childbirth, breastfeeding and car seat education classes;
- Comprehensive assessment of service needs in light of family and community resources;
- Home visits to provide education and support for breastfeeding, baby weight checks, parenting, immunization information and safe sleep;
- Ongoing coordination to assure access to needed services and support to help families attain their goals; and

- Developmental screening, psychosocial assessments, nutritional education, smoking cessation counseling or referrals as needed.

Humana will refer members to Healthy Start for these services when identified utilizing the Healthy Start Assessment Tool. The tool is used to determine eligibility for enrollment in Healthy Start's Care Coordination Program and is completed by the obstetrician at the initial visit. Eligibility is based on identified risk factors that may affect the health of the pregnancy. The goal of the program is to mitigate those risk factors. Members are automatically eligible when they exhibit one of the criteria that makes them automatically eligible, regardless of the Assessment Tool score (e.g., homelessness, history of abuse, etc.).

Providers are required to immediately notify Humana of an enrollee's pregnancy by calling **1-800-897-9823**, whether identified through medical history, examination, testing, claims or otherwise.

If a member becomes pregnant while on the plan, she is requested to call Humana's obstetrics case manager at **1-800-322-2758**. She should choose a Humana obstetrician or midwife for her care, and make an appointment to see this health care provider as soon as possible. She must also notify the Department of Children and Family (DCF) of the pregnancy by calling **1-866-762-2237**.

Before the last trimester, the member must choose a PCP for the baby. If the baby is enrolled with Humana and she does not choose a PCP for the baby, Humana will select one for her. If Humana selects the PCP and she does not want the one selected, she can change the child to another doctor. To select or change the baby's health plan, the member is instructed to call Choice Counseling at **1-877-711-3662** as soon as possible. She must also notify the Department of Children and Family (DCF) of the birth of the baby by calling **1-866-762-2237**.

DOMESTIC VIOLENCE, ALCOHOL AND SUBSTANCE ABUSE AND SMOKING CESSATION

PCPs should screen enrollees for signs of domestic violence and should offer referral services to applicable domestic violence prevention community agencies. See "Quality Enhancement" section 8.9 below.

PCPs should screen enrollees for signs of tobacco, alcohol and substance abuse as a part of prevention evaluation at the following times:

- Upon initial contact with enrollee;
- During routine physical examinations;
- During initial prenatal contact;
- When the enrollee shows evidence of serious overutilization of medical, surgical, trauma or emergency services; and
- When documentation of emergency room visits suggests the need.

PCPs should screen and educate enrollees regarding smoking cessation by:

- Making enrollees aware of and recognizing dangers of smoking.
- Teaching enrollees how to anticipate and avoid temptation.
- Providing basic information to the enrollee about smoking and successfully quitting.

- Encouraging the enrollee to quit.
- Encouraging the enrollee to talk about the quitting process.

QUALITY ENHANCEMENTS

Quality Enhancements are defined as certain health-related, community-based services to which Humana and its providers must offer and coordinate access for members. These include children's programs, domestic violence classes, pregnancy prevention, smoking cessation and substance abuse programs. These programs are not reimbursable. In addition to the covered services specified in this section, Humana and its providers should offer quality enhancements (QE) in community settings accessible to enrollees.

Humana may co-sponsor an annual training to providers, provided that the training meets the provider training requirements for the following programs. Services can be offered in collaboration with agencies such as early intervention programs, HealthyStart coalitions and local school districts.

The provider shall ensure documentation of the member's medical record of referrals to the community program and follow up on the enrollee's receipt of services from the community program.

QE programs shall include, but not be limited to, the following:

1. **Children's Programs** — Humana and its providers are required to provide regular general wellness programs targeted specifically toward members from birth to age 5, or make a good faith effort to involve enrollees in existing community children's programs.
 - a. Children's programs should promote increased use of prevention and early intervention services for at-risk members. Humana will approve claims for services recommended by the early intervention program when they are covered services and medically necessary.
 - b. Humana is required to offer annual training to providers who promote proper nutrition, breast-feeding, immunizations, CHCUP, wellness, prevention and early intervention services.
2. **Domestic Violence** — Providers must screen members for signs of domestic violence and offer referral services to applicable domestic violence prevention community agencies.
3. **Pregnancy Prevention** — Humana and its providers are required to conduct regularly scheduled pregnancy prevention programs or make a good faith effort to involve members in existing community pregnancy prevention programs, such as the Abstinence Education program. The programs should be targeted toward teen members, but should be open to all members, regardless of age, gender, pregnancy status or parental consent.
4. **Prenatal/Postpartum Pregnancy programs** — Humana is required to provide regular home visits conducted by a home health nurse or aide, counseling and educational materials to pregnant and postpartum enrollees who are not in compliance with the Health Plan's prenatal and postpartum programs.
5. **Smoking Cessation** — Humana and its providers are required to conduct regularly scheduled smoking cessation programs as an option for all members or make a good faith effort to involve members in existing community smoking cessation programs. Smoking cessation counseling must be available to all members. Providers should use the Quick Reference Guide to assist in identifying tobacco users and supporting and delivering effective smoking cessation interventions. Copies of the

guide may be obtained by contacting:

DHHS, Agency for Health Care Research & Quality (AHR) Publications Clearinghouse
P.O. Box 8547
Silver Spring, MD 20907-8547
1-800-358-9295

6. **Substance Abuse** — Humana is required to offer substance abuse screening training to providers.
 - Humana and its providers are required to offer targeted members either community- or plan-sponsored substance abuse programs.

QUALITY IMPROVEMENT REQUIREMENTS

Humana should monitor and evaluate the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to enrollees through:

- **Performance improvement projects (PIPs)** — Ongoing measurements and interventions, significant improvement to the quality of care and service delivery, sustained over time, in both clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.
- **Medical record audits** — Annual medical record reviews conducted by external quality review organizations (EQRO) to evaluate the quality outcomes concerning timeliness of, and enrollee access to, covered services.
- **Performance measures** — Data on patient outcomes as defined by the Health Plan Employee Data and Information Set (HEDIS®) or otherwise defined by the Agency.
- **Surveys** — Consumer Assessment of Health Plans Survey (CAHPS®) and Provider Satisfaction Survey.
- **Peer Review** — Conducted by the Plan to review a provider's practice methods and patterns and appropriateness of care.

COMMUNITY OUTREACH AND PROVIDER-BASED MARKETING ACTIVITIES

Providers need to be aware of and comply with the following requirements:

1. Health care providers may display health-plan-specific materials in their own offices. Providers are permitted to make available and/or distribute Humana marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all Managed Care Plans with which the provider participates. If a provider agrees to make available and/or distribute Humana's marketing materials, it should do so knowing it must accept future requests from other Managed Care Plans with which it participates. Providers are also permitted to display posters or other materials in common areas such as the provider's waiting room. Additionally, long-term care facilities are permitted to provide materials in admission packets announcing all Managed Care Plan contractual relationships.
2. Health care providers cannot orally or in writing compare benefits or provider networks among health plans, other than to confirm whether they participate in a health plan's network. If a provider can assist a recipient in an objective assessment of his/her needs and potential options to meet

those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.

3. Health care providers may announce a new affiliation with a health plan through general advertising (e.g., radio, television, websites). Providers may give their patients a list of health plans with which they contract.
4. Health care providers may co-sponsor events, such as health fairs and advertise with the health plan in indirect ways, such as television, radio, posters, fliers and print advertisements.
5. Health care providers shall not furnish lists of their Medicaid patients to the health plan with which they contract, or any other entity, nor can providers furnish other health plans' membership lists to the health plan; nor can providers assist with health plan enrollment.
6. For the health plan, health care providers may distribute information about non-health-plan specific health care services and the provision of health, welfare and social services by the State of Florida or local communities as long as inquiries from prospective enrollees are referred to the member services section of the health plan or the Agency's choice counselor/enrollment broker. Providers may refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office. They may also share information with patients from the Agency's website or CMS' website.

Providers may not:

- Offer marketing/appointment forms.
- Make phone calls or direct, urge or attempt to persuade recipients to enroll in the Managed Care Plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of the Managed Care Plan.
- Offer anything of value to induce recipients/enrollees to select them as their provider.
- Offer inducements to persuade recipients to enroll in the Managed Care Plan.
- Conduct health screenings as a marketing activity.
- Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.
- Distribute marketing materials within an exam room setting.
- Furnish to the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan.

FLORIDA MEDICAID PROVIDER NUMBER

All providers must be eligible for participation in the Medicaid program. If a provider is currently suspended or involuntarily terminated from the Florida Medicaid program whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider.

All providers are required to have a unique Florida Medicaid provider number in accordance with the guidelines of the Agency for Health Care Administration (AHCA). Each provider is required to have a National Provider Identifier (NPI) in accordance with Section 1173 (b) of the Social Security Act, as enacted by Section 4707 (a) of the Balanced Budget Act of 1997.

To comply with reporting requirements, Humana submits an electronic data file representing its credentialed and contracted provider network each week.

Having the proper Medicaid enrollment is critical. Incorrect enrollment can affect the way a health care provider or provider group is identified by AHCA and its Choice Counselors, as well as how it is listed in Physician Finder, Humana’s online provider directory.

- A health care provider may not have a “fully enrolled” or “straight” Medicaid ID that is active. Managed care organization (MCO) numbers are no longer accepted. Health care providers need to apply for a “straight” Medicaid ID, or what is sometimes referred to as a “fully enrolled” Medicaid ID.
- A health care provider may not have a “fully enrolled” or “straight” Medicaid ID under the provider’s own name and National Provider Identifier (NPI) for each specialty he or she practices. If a health care provider is practicing more than one specialty, he or she needs to have a Medicaid ID for each specialty.
- Provider groups may not have an NPI and Medicaid ID for each location and specialty (separate from the affiliated providers in the group). In order for group names and all affiliated locations to be published to AHCA in the data file used for member selection and Humana’s directories, the provider group needs to have its own NPI and “fully enrolled” or “straight” Medicaid ID. Please note: A provider group with more than one specialty needs a Medicaid ID for each specialty.
- Physician extenders and therapy providers (e.g., occupational, physical, respiratory or speech therapists) may not have “fully enrolled” or “straight” Medicaid ID numbers that are active. Physician extenders and therapists need to have an NPI and a “fully enrolled” or “straight” Medicaid ID under their individual name and practicing specialty. Please note: Therapy providers with more than one specialty need to have a Medicaid ID for each specialty.

PROVIDER CONTRACTS, CREDENTIALING AND RECREDENTIALING

If providers wish to become part of the Humana network, they may:

- Visit Humana.com/providers
- Choose “Join Our Network”
- Choose “Contracting with Humana”
- Complete online form

They may also contact their local Provider Contract office.

The following information will be needed for the contracting process:

- Physician/practice/facility name
- Service address with phone, fax and email information
- Mailing address, if different than service address
- Taxpayer identification number (TIN)
- Specialty
- Medicaid provider number

- National Provider Identifier (NPI)
- CAQH® number
- Lines of business (e.g., Medicaid, Medicare, etc.) of interest
- Type of contract (e.g., individual, group, facility)

Health care providers must be credentialed prior to network participation in order to treat Humana members.

Recredentialing occurs at least every three years. Some circumstances require shorter recredentialing cycles.

Humana participates with CAQH® (Council for Affordable Quality Healthcare).

Humana Network Operations/Credentialing will collect Florida Medicaid numbers for all Medicaid contracted providers at initial credentialing. The Medicaid numbers will be loaded into the credentialing system.

Humana Network Operations/Credentialing will collect full and accurate disclosure of any financial or ownership interest that the provider, or any principal, partner, or major shareholder thereof, may hold in any other Medicaid provider or health care related entity or any other entity that is licensed by the state to provide health or residential care and treatment to persons.

[Disclosure of Ownership Addendum for Participation with Humana Health Plans](#)

Network operations, or an agent thereof, will perform periodic office site reviews on all Medicaid contracted primary care physicians (PCPs) and OB-GYNs. The Humana Site Visit Tool will be used. Verification will include ensuring the statewide consumer call center telephone number, summary of Florida Patients' Bill of Rights and Responsibilities and consumer assistance notice are posted in the office.

[Practitioner Office Site Evaluation Tool \(POSET\)](#)

Network operations/credentialing will collect a signed Medicaid attestation from all Medicaid contracted PCPs.

[Medicaid Attestation for Primary Care Physicians](#)

Credentialing will perform a satisfactory Level II background check pursuant to s.409.907, F.S., for all treating providers not currently enrolled in Medicaid's fee-for-service program. Credentialing may verify the provider's Medicaid eligibility through the Agency for Health Care Administration electronic background screening clearinghouse at:

http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.

Humana Medical Plan will not contract with any provider who has a record of illegal conduct as identified in Section 435.04, F.S.

Credentialing will report providers suspended or terminated from the Humana Medical Plan to the appropriate authorities (e.g., National Practitioner Data Bank [NPDB], Office of Inspector General [OIG], General Services Administration [GSA] and state licensing board).

Credentialing will conduct regular license monitoring for all Medicaid contracted providers to verify active licensure.

Credentialing will review sanction information for any individual/entity identified above:

- List of Excluded Individuals and Entities (maintained by Office of the Inspector General [OIG]): <http://exclusions.oig.hhs.gov/>
- State Medicaid Agency Sanctions: [http://apps.ahca.myflorida.com/dm_web/\(S\(yhjnjtwnu1wjnr1c3tsmwxf\)\)/default.aspx](http://apps.ahca.myflorida.com/dm_web/(S(yhjnjtwnu1wjnr1c3tsmwxf))/default.aspx)
- General Services Administration (GSA) Exclusions: <https://www.sam.gov/portal/public/SAM/>

ADVANCED REGISTERED NURSE AND PHYSICIAN ASSISTANT SERVICES

Humana provides services rendered by advanced registered nurse practitioners (ARNP) and physician assistants (PA). Services may be rendered in the physician's practitioner's office, the patient's home, a hospital, a nursing facility or other approved place of service as necessary to treat a particular injury, illness or disease.

ARNPs are licensed and work in collaboration with practitioners pursuant to Chapter 464, F.S., according to protocol, to provide diagnostic and interventional patient care.

PAs are certified to provide diagnostic and therapeutic patient care and be fully licensed as a PA as defined in Chapter 458 or 459, F.S. The services must be provided in collaboration with a practitioner licensed pursuant to Chapter 458 or 459, Florida Statutes.

Humana complies with provisions of the Medicaid Physician Practitioner Services Coverage and Limitations Handbook. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Physician Practitioner Services Coverage and Limitations Handbook.

PHARMACY

Medicaid Preferred Drug List

The Humana Medicaid Preferred Drug List (PDL) uses the same formulary as the Agency for Health Care Administration (AHCA) and as such also has the same prior authorization requirements, step therapy requirements and dispensing limits. Since the Humana Preferred Drug List (PDL) is a closed formulary, some drugs are non-preferred. Please consider the alternative drugs available for your Humana (Medicaid)-covered patients.

Physicians can request an exception to the four restricted categories: not normally covered, step therapy medicines, medicines with prior authorization or medicines needing a quantity over the limits in place; by calling Humana Pharmacy Clinical Review (HCPR) at 1-800-555-CLIN (1-800-555-2546) or by fax at 1-877-486-2621. The call center is available Monday – Friday, 8 a.m. – 6 p.m. Eastern time. Please have patient demographic and medical information ready to answer questions.

You may also obtain forms and information at **Humana.com/pa**.

For Botox delivered/administered in physician's office, clinic, outpatient or home setting (fee-for-service providers only) you may contact us at:

- Humana.com/medpa
- 1-866-461-7273 (Monday – Friday, 8 a.m. – 6 p.m. Eastern time)

The Plan shall not cover barbiturates and benzodiazepines for dual eligible Medicare and Medicaid enrollees.

Pharmacy Network

If newly enrolled patients are using a pharmacy not in our network, Humana will continue to allow the prescriptions to process for 60 days during the continuity-of-care period. Prior to the end of the continuity of care 60-day time frame, Humana and its providers will educate its enrollees on how to access their drug benefit through Humana's participating pharmacy provider network.

After the regional implementation of the MMA program, Humana will continue to refill prescriptions during the continuity of care period. During the continuity of care period, Humana and its Providers will educate new enrollees on how to access their prescription drug benefit through Humana's participating provider network.

Humana has an over-the-counter (OTC) program through PrescribeIT (1-800-526-1490). The benefit gives each household up to a \$25 a month allowance of over-the-counter products. Orders will be shipped to the enrollee's home by UPS or the U.S. Postal Service. There is no charge for shipping. Please allow 10 to 14 working days from when the order is received.

Counterfeit-proof Pads

Medicaid practitioners who prescribe drugs are required to use a counterfeit-proof prescription pad for Medicaid prescriptions. Any Medicaid-participating prescribers or prescribers who write prescriptions for Medicaid recipients are required to use the counterfeit-proof pad.

HEALTHY BEHAVIORS PROGRAM

Healthy Behaviors are programs offered by Humana that encourage and reward behaviors designed to improve the enrollee's overall health. Programs administered by Humana must comply with all applicable laws, including fraud and abuse laws that fall within the purview of the United States Department of Health and Human Services, Office of Inspector General (OIG). The following Healthy Behaviors programs are offered to Humana members:

- **Baby Well Visit** — Member enrolls by calling 1-800-611-1467 and completing three well-baby visits before 18 months of age. They'll receive a \$10 gift card per visit, up to three after the provider claim is validated by Humana (up to three rewards totaling \$30).
- **Pediatric Well Visit** — Member enrolls annually by calling 1-800-611-1467 and completing a well-child visit. They'll receive a \$20 gift card after the provider claim is validated by Humana (up to one reward of \$20 per year).
- **Humana Fit** — Members 18 years and older can be self-, plan- or provider-referred by calling **1-855-330-8053**. Once enrolled in the six-month program, members obtain baseline biometrics and

medical clearance at an initial primary care physician (PCP) visit. They'll receive a \$25 gift card with Humana's receipt of a completed provider medical clearance/biometrics form. At program completion, members obtain a second biometric screening with their PCP, and they'll receive another \$25 gift card with Humana's receipt of completed provider medical clearance/biometrics form. Members also have the following incentives offered as members of the Fit program: a personal health coach, six telephonic nutritional counseling sessions with a nutritionist/dietician, monthly newsletters covering a variety of topics related to weight management and healthy living, a weight scale and a walking kit (includes a step counter, a drawstring backpack, a water bottle and a towel). Participants may receive up to two rewards of \$25 per year; up to one scale and walking kit per lifetime.

- **Mom's First Prenatal and Postpartum** — Members can be self-, plan- or provider-referred by calling **1-800-322-2758, ext. 1500290** and completing all prenatal and postpartum visits with their provider; they'll receive a \$30 gift card (up to one reward of \$30 per pregnancy).
- **Smoking Cessation** — Members 18 years and older can be self-, plan- or provider-referred by calling **1-800-221-5487**. Once members complete the 6-month program as smoke-free, they'll receive a \$30 gift card. A second option available is for members who complete the six-month program as smoke-free with the use of a prescribed pharmacological agent will receive a \$50 gift card instead (up to one reward of \$30 per year for standard completion or up to one reward of \$50 per year for pharmacological completion).
- **Substance Abuse** — Members 18 years and older can be self-, plan- or provider-referred by calling Beacon Health Options at **1-800-221-5487**. Members will receive a \$10 gift card for enrolling in the six-month program. Then at 90 days of sobriety, they receive a \$20 gift card. At 180 days of sobriety, they'll receive another \$20 gift card and will complete the program (up to three rewards totaling \$50).

You can find these materials here: humana.com/provider/support/clinical/medicaid-materials/florida.

Included in the programs is a medically approved smoking cessation program, a medically directed weight loss program and a medically approved alcohol or substance abuse recovery program.

Humana identifies enrollees who smoke, are morbidly obese, or are diagnosed with alcohol or substance abuse in order to establish written agreements to secure the enrollees' commitment to participate in these programs.

Once the enrollee is identified and enrolled in the program, Humana may inform them about the healthy behavior programs, including incentives and rewards.

As part of its smoking cessation program, the Managed Care Plan shall provide participating PCPs with the Quick Reference Guide to assist in identifying tobacco users and supporting and delivering effective smoking cessation interventions.

Rewards may take 90 to 180 days or greater for the member to receive. Incentives and rewards are non-transferrable. Members will lose access to earned incentives and rewards if they voluntarily disenroll from the Humana plan or lose Medicaid eligibility for more than one-hundred eighty (180) days.

Healthy Behaviors Overview

Healthy Behaviors programs	Administered by	Duration	How to enroll
Smoking Cessation Program*	Beacon Health Options Encompass Program	6 months	Self-, provider- or plan-referred by calling 1-800-221-5487
Substance Abuse Program*			
Humana Fit Program	Humana and Physician well visits	6 months and 2 physician visits	Self-, provider- or plan-referred by calling 1-855-330-8053
Mom's First Prenatal and Postpartum Program	Humana and Physician visits	All prenatal visits and 1 postpartum visit	Self-, provider- or plan-referred by calling 1-800-322-2758, ext. 1500290
Baby Well Visits Program	Humana and Physician well visits	3 physician visits	Member enrolls by calling 1-800-611-1467
Pediatric Well Visit Program	Humana and Physician well visits	1 physician visit	Member enrolls by calling 1-800-611-1467

**For Region 1 members, all behavioral health services are administered through Access Behavioral Health (ABH). Only these two Healthy Behavior programs are administered through Beacon Health Options. As noted above, your office or the member may call Beacon Health Options directly to enroll.*

Program Claims Codes

Program	Age group	CPT codes	ICD-10-CM diagnosis codes	HCPCS codes
Baby Well Visits Program	0-18 months	Well visit: 99381–99385, 99391–99395, 99461	Well visit: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.9	HCPCS: G0438, G0439

Pediatric Well Visit Program	2-21 years	Well visit: 99381–99385, 99391–99395, 99461	Well visit: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.9	HCPCS: G0438, G0439
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Information is current as of January 2016. Program descriptions and rules are subject to change. Please contact your Provider Relations Representative with questions.

EMERGENCY AND NONEMERGENCY TRANSPORTATION

- For emergency transportation services, call 911.
- If a member needs a ride to a health care appointment that is not an emergency or to the pharmacy right after a doctor's visit, the member may call LogistiCare at **1-866-779-0565**. The member must call at least 24 hours before the appointment time.

INPATIENT HOSPITAL SERVICES

For members up to age 21 and pregnant adults, the plan shall provide up to 365 days of health-related inpatient care, including behavioral health each year. Prior authorization may apply.

Physical and Behavioral Health

- The plan will cover up to 45 days of inpatient coverage and up to 365 days of emergency inpatient care, including behavioral health.
- Prior authorization and other limits may apply.

Transplant Services

- The plan will cover medically necessary transplants and related services.
- Prior authorization and other limits may apply.

MINORITY RECRUITMENT AND RETENTION PLAN

Humana makes every effort to recruit and retain providers of all ethnicities in order to support the cultural preferences of its members. Humana's provider networks are not closed to new provider participation barring provider willingness to accept contractual requirements, contractual rates and satisfy all credentialing and regulatory requirements. Humana reviews and accommodates all provider nomination requests, when appropriate, from both members and providers to ensure all providers are equally represented in Humana's provider network.

As part of this process, Humana collects and publishes spoken languages in our provider directories on Physician Finder. Please be sure to accurately indicate all languages spoken in your office(s) on your Humana re-credentialing application and/or CAQH application, or contact your Provider Relations representative to have updates made.

Native Americans

Humana does not impose enrollment fees, premiums or similar charges on Indians served by an Indian health care provider; Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization; or through referral under contract health services, in accordance with the American Recovery and Reinvestment Act of 2009.

SERVICE LEVEL AGREEMENTS

Humana's contract with AHCA includes required service level agreements. Humana works with its network health care providers to achieve the following commitments:

Network adequacy

- Varying by region, 85 percent to 90 percent of PCPs are accepting new members.
- Ninety percent of specialists are accepting new members.
- Varying by region, 30/35/40 percent of PCPs offer after-hours appointments.
- No more than 5/8/10 percent (varies by region) of hospital admissions occur in nonparticipating facilities (excludes continuity of care and emergency room).
- No more than 8/10 percent (varies by region) of specialty care is provided by nonparticipating specialists.

Electronic Health Records (EHR)

- Use requirements: Depending on region, 45 percent to 60 percent of health care providers are:
 - Using EHR in a meaningful manner.
 - Using a certified electronic health exchange to improve quality of health care.
 - Using certified EHR to submit clinical quality and other Department of Health and Human Services (DHHS) prescribed measures.

FLORIDA HEALTH EXCHANGE INFORMATION

The Managed Care Plan shall encourage its providers to connect to the Florida Health Information Exchange (HIE) and promote provider use of the HIE, including educating providers on the benefits of using the HIE and the availability of incentive funding. The Managed Care Plan shall encourage network providers to participate in the Agency's Direct Secure Messaging (DSM) service when it is implemented.

ASSISTIVE CARE SERVICES

Assistive care services (ACS) are an integrated set of 24-hour services only for eligible Medicaid enrollees. The assistive care service is a required service in the statewide Medicaid Managed Care program under both the long-term-care program and the Managed Medical Assistance program.

Required Covered Services under MMA:

- | | |
|--|--|
| • Advanced registered nurse practitioner | • Behavioral health services |
| • Ambulatory surgical center services | • Birth center and licensed midwife services |
| • Assistive care services | • Clinic services |

- Chiropractic services
- Dental services
- Child health check-up
- Immunizations
- Emergency services
- Emergency behavioral health services
- Family planning services and supplies
- Healthy Start services and nursing care
- Hearing services
- Home health services and nursing care
- Hospice services
- Hospital services
- Laboratory and imaging services
- Medical supplies, equipment, prostheses and orthoses
- Optometric and vision services
- Physician assistant services
- Physician services
- Podiatric services
- Prescribed drug services
- Renal dialysis services
- Therapy services
- Transportation services

Additional benefits covered under MMA:

- Primary care visits (for adults who are not pregnant)
- Home health care (for adults who are not pregnant)
- Physician home visits
- Prenatal/perinatal visits
- Outpatient services
- Over-the-counter (OTC) medication supplies
- Adult dental services
- Waived copayments
- Vision services
- Hearing services
- Newborn circumcision
- Adult pneumonia vaccine
- Adult influenza vaccine
- Adult shingles vaccine
- Post discharge meals
- Nutritional counseling
- PET therapy
- Art therapy
- Medically related lodging and food

PREAUTHORIZATION AND REFERRAL PROCEDURES

Providers must determine whether preauthorization or notification is required with respect to medical services rendered to any Humana members. To make this determination, providers must review Humana's preauthorization and notification lists (available on **Humana.com**, in the Provider Tools and Resources section or call Customer Service for assistance in locating the lists) which provide a list of medical services that require preauthorization or notification. (Note: Precertification, preadmission, preauthorization and notification requirements all refer to the same process of preauthorization.)

Humana will update the lists periodically and notify providers of revisions in accordance with the time frame specified in the provider agreement. In addition to **Humana.com**, preauthorization or notification requirements for a service may be obtained by contacting Humana Customer Service.

Referrals for service can be submitted and viewed by participating and registered providers on www.Availty.com and **Humana.com**.

For hospital admission, the provider must access **Humana.com**, [Availty.com](http://www.Availty.com) or call the number listed on the back of the member's ID card. The following information is required for each hospital admission:

- Subscriber's name
- Member's ID number, name and date of birth
- Date of actual or proposed admission
- Date of proposed procedure
- Bed type: inpatient or outpatient
- Federal tax ID number of treatment facility or hospital
- Applicable ICD diagnosis code
- Caller's telephone number
- Attending physician's telephone number

For urgent authorizations or notifications, call clinical intake (available 24 hours a day) at **1-800-523-0023**. Representatives are also available 8 a.m. – 8 p.m. Eastern time, Monday – Friday (excluding major holidays). Press "0" or say "representative" for live help. Have your tax ID number available.

MEDICAL RECORDS REQUIREMENTS

For each Medicaid enrollee, the provider should maintain detailed and legible medical records that include the following:

- Include the enrollee's identifying information, including name, enrollee identification number, date of birth, gender and legal guardianship (if any);
- Include a summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications;
- Include all services provided. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases;
- Document referral services in enrollees' medical/case records;
- Each record shall be legible and maintained in detail;
- All records shall contain an immunization history;
- All records shall contain information relating to the enrollee's use of tobacco, alcohol and drugs/substances;
- All records shall contain summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow-up;
- All records shall reflect the primary language spoken by the enrollee and any translation needs of the enrollee;
- All records shall identify enrollees needing communication assistance in the delivery of health care services;
- All entries shall be dated and signed by the appropriate party;
- All entries shall indicate the chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider;
- All entries shall indicate studies ordered (e.g., laboratory, X-ray, EKG) and referral reports;
- All entries shall indicate therapies administered and prescribed;
- All entries shall include the name and profession of the provider rendering services (e.g., M.D., D.O., O.D.), including the signature or initials of the provider;
- All entries shall include the disposition, recommendations, instructions to the enrollee, evidence of whether there was follow-up and outcome of services;
- Include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of 13; and
- Include copies of PASRR screening and evaluations completed in accordance with the Rule 59G-1.040, F.A.C for enrollees admitted to or residing in a nursing facility under any provision of this contract.

Humana shall maintain written policies and procedures for enrollee advance directives that address how the Plan will access copies of any advance directives executed by the enrollee.

All medical/case records shall contain documentation that the enrollee was provided with written information concerning the enrollee's rights regarding advance directives (written instructions for living will or power of attorney) and whether the enrollee has executed an advance directive. Neither the Managed Care Plan, nor any of its providers shall, as a condition of treatment, require the enrollee to execute or waive an advance directive.

Humana has a form called "5 Wishes" that an enrollee can use to make his or her health care wishes known. This form can serve as advance directives. The member may call Humana Health Services at 1-800-322-2758 for a copy of this form.

Humana and providers shall be responsible for coordination of care for new enrollees transitioning to Humana or another plan or delivery system and shall assist with obtaining the enrollee's medical/case records. This should be done within 30 days.

CONFIDENTIALITY OF MEDICAL RECORDS

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

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

Providers will ensure compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR, Part 431, Subpart F.

CLAIMS AND ENCOUNTER SUBMISSION PROTOCOLS AND STANDARDS

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:

Medical Claims:

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

Encounters:

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

Behavioral Health Claims:

Region 1 only

Access Behavioral Health
1221 W. Lakeview Ave.
Pensacola, FL 32501

Behavioral Health Claims:

Regions 6, 9, 10, and 11

Beacon Health Options
Attn: Claims Dept.
10200 Sunset Dr.
Miami, FL 33173-3033

When filing an electronic claim, you will need to utilize one of the following Payer IDs:

- 61101 for fee-for-service claims
- 61102 for encounter claims

For claim payment inquiries or complaints, please contact Humana customer service at **1-800-448-6262 (1-800-4HUMANA)** or your provider contracting representative. You may also email questions to: **ebusiness@humana.com**. Submit claim disputes to:

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

If there is a factual disagreement with a response, send an email with the reference number to **Humanaproviderservices@humana.com**.

For information regarding electronic claim submission, contact your local provider contracting representative or visit **Humana.com/providers** and choose "Claims Resources" then "Electronic Claims & Encounter Submissions" or www.Availity.com.

In addition to the claim payment provisions outlined in the Medicaid Addendum to your Provider Agreement, Humana should reimburse providers for Medicare deductibles and coinsurance payments for Medicare dual-eligible enrollees according to the lesser of the following:

- Rate negotiated with the provider; or
- Reimbursement amount as stipulated in Section 409.908 F.S.

Following is a list of some of the commonly used claims clearinghouses and phone numbers:

Availity [®]	http://www.availity.com	1-800-282-4548
ZirMed [®]	http://www.zirmed.com	1-877-494-7633
Trizetto	http://www.trizetto.com	1-800-556-2231
McKesson	http://www.mckesson.com	1-800-782-1334
Capario SM	http://www.capario.com	1-800-792-5256
SSI Group	http://www.thessigroup.com	1-800-881-2739

AHCA requires 100 percent encounter submissions:

- 95 percent must pass through state system
- Necessitates appropriate provider registration and documentation
- Fee-for-service and capitated providers included

Encounters and claims identify members who have received services:

- Decreases the need for medical record review during HEDIS
- Will be critical for future world of Medicaid Risk Adjustment
- Helps identify members receiving preventive screenings – decreases members appearing in GAP reports

Sanctions for noncompliance can include liquidated damages and even enrollment freezes.

COMMON SUBMISSION ERRORS AND HOW TO AVOID THEM

Common rejection or denial reasons:

1. Patient not found
2. Insured subscriber not found
3. Patient birthdate on the claim does not match that found in our database
4. Missing or wrong information
5. Invalid HCPCS code submitted
6. No authorization or referral found

How to avoid these errors:

1. Confirm that patient information received and submitted is accurate and correct.
2. Ensure that all required claim form fields are complete and accurate.
3. Obtain proper authorizations and/or referrals for services rendered.

TIMELY FILING

Providers are required to file timely claims/encounters for all services rendered to Medicaid members. Timely filing is an essential component of Humana's HEDIS reporting and can ultimately affect how a plan and its providers are measured in member preventive care and screening compliance.

Claims should be filed as soon as possible but no later than 6 months after the date of service per state guidelines.

Encounter claims should be filed within 30 days.

The encounter data submission standards required to support encounter data collection and submission are defined by the Agency in the Medicaid Companion Guides, Pharmacy Payer Specifications and this section. In addition, the Agency will post encounter data reporting requirements on the following websites:

- http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_CompanionGuides/tabId/62/Default.aspx
- http://portal.flmmis.com/FLPublic/Provider_Pharmacy/tabId/52/Default.aspx

ERAS AND EFTS

Providers may register to receive their Humana electronic remittance advice (ERA) and payments/electronic funds transfer (EFT) and get paid up to seven days faster. The enrollment process is quick and easy:

- Sign into the secure provider website at **Humana.com/providers**
- Select the "ERA/EFT Setup-Change Request"
- Complete the form

You may also access the registration form from the public portal from the **Humana.com/providers** page:

- Select "ERA/EFT"
- Choose the "ERA/EFT Setup-Change Request" link
- Registration requires two check numbers from claims paid by Humana for validation

Email questions to: **ebusiness@humana.com**.

CULTURAL COMPETENCY PLAN

Participating providers are expected to provide services in a culturally competent manner which includes, but is not limited to, removing all language barriers to service and accommodating the special needs of the ethnic, cultural and social circumstances of the patient.

Participating providers must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care including, but not limited to, 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.

Humana recognizes cultural differences and the influence that race, ethnicity, language and socioeconomic status have on the health care experience and health outcomes. It is committed to developing strategies that eliminate health disparities and address gaps in care.

A report by the Institute of Medicine in 2002 confirmed the existence of racial and ethnic disparities in health care. “Unequal Treatment” found racial differences in the type of care delivered across a wide range of health care settings and disease conditions, even when controlling for socioeconomic status factors such as income and insurance coverage. Annual national health care disparities reports from the Agency for Healthcare Research and Quality (AHRQ) confirm that these gaps persist in the American health care system.

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

Humana offers a number of initiatives to deliver services to all members regardless of ethnicity, socioeconomic status, culture and primary language. These include language assistance services, race and ethnicity data collection and analysis, internal staff training and Spanish resources. Other initiatives give providers resources and materials, including tools from health-related organizations that support awareness of gaps in care and information on culturally competent care.

You may view a complete copy of Humana’s Cultural Competency Plan on Humana’s website at **Humana.com/providers/clinical/resources.aspx**. To request a paper copy of Humana’s Cultural Competency Plan, please contact Humana customer service at 1-800-4HUMANA (1-800-448-6262) or call your provider contracting representative. The copy of Humana’s Cultural Competency Plan will be provided at no charge to the provider.

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS

1. A member has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy.
2. A member has the right to a prompt and reasonable response to questions and requests.
3. A member has the right to know who is providing medical services and who is responsible for his or her care.
4. A member has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
5. A member has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
6. A member has the right to know what rules and regulations apply to his or her conduct.
7. A member has privacy rights under the Health Insurance Portability and Accountability Act (HIPAA). This is a federal law that protects your health information. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think your rights are being denied or your health information isn't being protected.
8. A member has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
9. A member has the right to participate in decisions regarding his or her health care, including the right to refuse treatment except as otherwise provided by law.
10. A member has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
11. A member who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
12. A member has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
13. A member has the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have the charges explained.
14. A member has the right to request and receive a copy of his or her medical records, and request that they be amended or corrected.
15. A member has the right to be furnished health care services in accordance with federal and state regulations.
16. A member has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap or source of payment.

17. A member has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
18. A member has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
19. A member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
20. The state must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state Agency treat the enrollee.
21. A member has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

MEMBER RESPONSIBILITIES

1. A member is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his or her health.
2. A member is responsible for reporting unexpected changes in his or her condition to the health care provider.
3. A member is responsible for reporting to the health care provider whether he or she understands a possible course of action and what is expected of him or her.
4. A member is responsible for following the treatment plan recommended by the health care provider.
5. A member is responsible for keeping appointments, and when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
6. A member is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
7. A member is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
8. A member is responsible for following health care facility rules and regulations affecting patient care and conduct.

FRAUD AND ABUSE POLICY

Provider must incorporate a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse.

Humana and AHCA should be notified immediately if a physician/provider or their office staff:

- Is aware of any physician/provider that may be billing inappropriately, e.g., falsifying diagnosis codes and/or CPT codes, or billing for services not rendered;
- Is aware of a member intentionally permitting others to use his/her member ID card to obtain services or supplies from the plan or any authorized plan provider;
- Is suspicious that someone is using another member's ID card;
- Has evidence that a member knowingly provided fraudulent information on his/her enrollment form that materially affects the member's eligibility in the plan.

Providers may provide the above information via an anonymous phone call to Humana's Fraud Hotline at **1-800-614-4126**. All information will be kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Humana ensures no retaliation against callers because Humana has a zero tolerance policy for retaliation or retribution against any person who reports suspected misconduct.

Providers may also contact Humana at **1-800-4HUMANA (1-800-448-6262)** and AHCA at **1-888-419-3456, option 5**.

In addition, providers may use the following contacts:

Telephonic:

- Special Investigations Unit (SIU) Direct Line: **1-800-558-4444 ext. 8187** (Monday – Friday, 8 a.m. – 5:30 p.m. Eastern time)
- Special Investigations Unit Hotline: **1-800-614-4126** (24/7 access)
- Ethics Help Line: 1-877-5-THE-KEY (1-877-584-3539)
Email: siureferrals@humana.com or ethics@humana.com
Web: Ethicshelpline.com

HEALTH, SAFETY AND WELFARE

Suspected cases of abuse, neglect and/or exploitation must be reported to the state's Adult Protective Services Unit. The Florida Adult Protective Services has the responsibility for investigating allegations of abuse and neglect of elders and individuals with disabilities. This includes, but is not limited to:

- **Abuse** — Non-accidental infliction of physical and/or emotional harm.
- **Physical Abuse** — Causing the infliction of physical pain or injury to an older person.
- **Sexual Abuse** — Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities; touching, fondling, sexual threats, sexually inappropriate remarks or any other sexual activity with an older person when the older person is unable to understand, unwilling to consent, threatened or physically forced to engage in sexual activity.
- **Psychological Abuse** — Includes, but is not limited to, name calling, intimidation, yelling and swearing. May also include ridicule, coercion and threats.
- **Emotional Abuse** — Verbal assaults, threats of maltreatment, harassment or intimidation intended to compel the older person to engage in conduct from which he or she wishes and has a right to abstain, or to refrain from conduct in which the older person wishes and has a right to engage.
- **Neglect** — Repeated conduct or a single incident of carelessness that results or could reasonably be expected to result in serious physical or psychological/emotional injury or substantial risk of death (this includes self-neglect and passive neglect).
- **Exploitation** — Illegal use of assets or resources of an adult with disabilities. It includes, but is not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion or in any manner contrary to law.

Indicators of abuse, neglect and exploitation

Physical indicators

1. **Unexplained bruises or welts:**
 - On face, lips, mouth, torso, back, buttocks, thigh in various stages of healing
 - Reflecting shape of article used to inflict (electric cord or belt buckle) in several different surface areas
2. **Unexplained fractures:**
 - To skull, nose, facial structure, in various stages of healing
 - Multiple or spiral fractures
3. **Unexplained burns:**
 - Cigar, cigarette burns, especially on palms, legs, arms, back or soles of feet
 - Immersion burns (sock-like, glove-like, doughnut shaped on buttocks)

- Patterned like objects (electric burner, etc.)
- 4. **Unexplained lacerations:**
 - Mouth, lips, gums, eye or to external genitalia
- 5. **Sexual abuse:**
 - Difficulty in walking/sitting
 - Torn, shredded or bloody undergarments
 - Bruises or bleeding in external genitalia, vaginal or anal areas
 - Venereal disease
 - Pregnancy
- 6. **Other:**
 - Severe or constant pain
 - Obvious illness that requires medical or dental attention
 - Emaciated (so that individual can hardly move or so thin bones protrude)
 - Unusual lumps, bumps or protrusions under the skin
 - Hair thin as though pulled out, bald spots
 - Scars
 - Lack of clothing
 - Same clothing all of the time
 - Fleas, lice on individual
 - Rash, impetigo, eczema
 - Unkempt, dirty
 - Hair matted, tangled or uncombed

Behavioral indicators

1. **Destructive behavior of victim:**
 - Assaults others
 - Destroys belongings of others or themselves
 - Threatens self-harm or suicide
 - Inappropriately displays rage in public
 - Steals without an apparent need for the things stolen
 - Recent or sudden changes in behavior or attitudes
2. **Other behavior of victim:**
 - Afraid of being alone
 - Suspicious of other people and extremely afraid others will harm them
 - Shows symptoms of withdrawal, severe hopelessness, helplessness
 - Constantly moves from place to place
 - Frightened of caregiver
 - Overly quiet, passive, timid
 - Denial of problems
3. **Behavior of family or caregiver**
 - Marital or family discord
 - Striking, shoving, beating, name-calling, scapegoating

- Hostile, secretive, frustrated, shows little concern, poor self-control, blames adult, impatient, irresponsible
- Denial of problems
- Recent family crisis
- Inability to handle stress
- Recent loss of spouse, family member or close friend
- Alcohol abuse or drug use by family
- Withholds food, medication
- Isolates individual from others in the household
- Lack of physical, facial, eye contact with individual
- Changes doctor frequently without specific cause
- Past history of similar incidents
- Resentment, jealousy
- Unrealistic expectations of individual

Providers are required to report adverse incidents to the agency immediately but not more than 24 hours of the incident. Reporting will include information including the enrollee's identity, description of the incident and outcomes including current status of the enrollee. It is your responsibility as the provider to ensure that abuse, neglect and exploitation training occurs and to maintain necessary documentation of this training for the employees that have contact with the plan (managed care organization) enrollees. You may be requested to make such documentation available.

You may use the "Adult Abuse, Neglect and Exploitation Guide for Professionals" as a training tool. It is available at: <http://www.Dcf.State.Fl.Us/programs/aps/docs/guideforprofessionalsrevisedjune2009.pdf>.

Suspected elder abuse, neglect, or exploitation may be reported 24 hours a day seven days a week to the central abuse hotline at 1-800-96-ABUSE (1-800-962-2873). You may also make a report online at: <http://www.Dcf.State.Fl.Us/abuse/report/index.asp>.

When reporting suspected or confirmed abuse, neglect, or exploitation, please report the following information (if available):

- Victim's name, address or location, approximate age, race and gender;
- Physical, mental or behavioral indications that the person is infirmed or disabled;
- Signs or indication of harm or injury or potential harm or injury (physical description or behavioral changes);
- Relationship of the alleged person responsible to the victim, if possible. If the relationship is unknown, a report will still be taken if other reporting criteria are met.
- Medicaid managed care organizations may be required to ensure that all direct care providers have knowledge of and attest they will maintain compliance with staff training relative to abuse, neglect and exploitation.

ADVERSE INCIDENT REPORTING

Humana's Risk Management Program includes adverse incident reporting and management system for critical events that negatively impact the health, safety or welfare of members.

Participating providers should:

- Identify an adverse incident. Some examples, death, wrong surgical procedure, wrong site or wrong patient, surgical procedure to remove foreign objects remaining from a surgical procedure.
- Report the adverse incident to the appropriate entity (police, adult protective services, etc.).
- Call 911 if the member is in immediate danger.
- Report the adverse incident to the health plan and Department of Children and Family Services (DCFS) within 24 hours of identifying the incident.
- Report suspected abuse, neglect and exploitation of a member immediately in accordance with s.39-201 and Chapter 415, F.S.
- Complete the AHCA Critical Incident Report located in the AHCA Medicaid website or filling out the below report and submit to Humana's risk management team within 48 hours at:
RiskManagementAdministration@humana.com. Or call the risk management department toll free at **1-855-281-6067**.
 - [Critical Incident Report](#)

PATIENT-CENTERED MEDICAL HOME (PCMH)

Patient-Centered Medical Home (PCMH) is a transformative model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and fosters greater accountability for both patient and physician.

PCMHs are expected to provide evidence-based services to patients and integrate care with specialty and subspecialty practices. The medical home is required to adhere to the following tenets:

Enhance Access and Continuity — Accommodate patient's needs with access and advice during and after regular office hours, give patients and their families information about their medical home and provide patients with team-based care.

Identify and Manage Patient Populations — Collect and use data for population management.

Plan and Manage Care — Use evidence-based guidelines for preventive, acute and chronic care management, including medication and mental health management.

Provide Self-care Support and Community Resources — Assist patients and their families in self-care management with information, tools and resources.

Track and Coordinate Care — Track and coordinate tests, referrals and transitions of care.

Measure and Improve Performance — Use performance and patient experience data for continuous quality improvement.

Humana's patient-centered medical home (PCMH) program works to empower patients as they interact with their primary care physicians (PCPs) and health care delivery teams (e.g., family, therapist, specialist, diagnostic center, hospital and laboratory). The PMCH program focuses on a team-based approach to health care delivery. Open communications between the health care team and patient allow for the patient to be more actively involved in health care decisions with a potential for better health outcomes and cost-effective treatment of ongoing health conditions.

According to the Agency for Healthcare Research and Quality, a PCMH program includes the following functions that transform traditional primary care into advanced primary care:

- **Comprehensive care:** A team that includes physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators and care coordinators, guides patients through the health care delivery system.
- **Patient-centered care:** The patient is primary in the relationship and drives decisions that influence his or her health. Physicians provide education and establish a plan of care.
- **Coordinated care:** The PCP communicates with the health care delivery team and manages coordination of care.

- **Accessible services:** The patient's access-to-care preferences are important. Shorter wait times, urgent needs, after-hours and around-the-clock access, as well as openness to different types of communication besides the telephone, are taken into consideration by the physician.
- **Quality and safety:** The PCP uses evidence-based medicine and clinical decision-support tools to guide the patient and health care delivery.

PCPs who are interested in the PCMH program, certification requirements and the benefits may email pcmh@humana.com.

MEDICAID ADVISORY PANEL

Humana recognizes that our Medicaid plan is but one spoke in a wheel of health care providers, community organizations, health plans and other programs that provide essential services, programs and resources to enable Medicaid-qualified members to maintain quality of life and optimal well-being.

To ensure that the needs of members are being addressed and opportunities for improvement are being identified, Humana has developed a Medicaid Advisory Panel.

The panel includes community providers, such as medical service organizations and hospital corporations, nonprofit organizations, community agencies that serve the Medicaid population, a member advocate and various Humana leaders.

PROVIDER REWARDS AND INCENTIVES

Provider Quality Bonus — Program aims to promote improvement and quality by providing additional financial compensation to PCP centers that demonstrate high levels of performance for select quality factors.

Eligibility:

- PCP must have an open panel for Medicaid line of business.
- PCP serves a minimum of 50 Medicaid member assignments.

Programs may not be available in all regions. Please contact your provider relations representative.

PROVIDER RESOURCE WEBSITE

Providers may obtain plan information from **Humana.com/providers**.

This information includes, but is not limited to, the following:

- Health and wellness programs
- Clinical practice guidelines
- Provider publications (including Provider Manual – Florida Appendix)
- Pharmacy services
- Claim resources
- Quality resources
- What's new

Why register for **Humana.com**?

- Make fewer phone calls
- Save time and costs
- Get secure, real-time access to patient information:
 - Eligibility and benefits
 - View member ID cards
 - Care alerts and member summary
 - Preauthorization and referrals submissions and management
 - Send attachments
 - Claims status and remittance info
 - Medical records management

Humana created a website specific to Florida Medicaid containing resources and updates for providers, viewable at **humana.com/provider/support/clinical/medicaid-materials/florida**.

For help or more information regarding Web-based tools, email **ebusiness@humana.com**.

PROVIDER TRAINING

Providers are expected to adhere to all training programs identified by the contract and Humana as compliance-based training. This includes agreement and assurance that all affiliated participating providers and staff members are trained on the identified compliance material.

As part of the training requirements, providers must complete annual compliance training on the following topics:

- Florida Medicaid Provider Orientation Training
- Compliance and Fraud, Waste and Abuse
- Cultural Competency
- Health, Safety and Welfare (Abuse, Neglect and Exploitation)

All new providers will also receive Humana's Medicaid Provider Orientation.

Providers must also complete annual required training on compliance and fraud, waste and abuse to ensure specific controls are in place for the prevention and detection of potential or suspected fraud and abuse as required by s. 6032 of the federal Deficit Reduction Act of 2005.

Providers and members of their office staff can access these online training modules seven days a week, 24 hours a day at **Humana.com/providers**. Sign in with your existing user ID and password. If your organization is not yet registered, registration can be completed immediately. Choose "Resources," locate the "Compliance" section and then choose "Required Compliance Events."

Additional provider training: Visit **Humana.com/providers** and choose "Web-based Training Schedule" under "Critical Topics."

AVAILITY

Humana has partnered with Availity to allow providers to reference member and claim data for multiple payers using one login. Availity provides the following benefits:

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

To learn more, call **1-800-282-4548** or visit **<http://www.Availity.com>**.

HELPFUL NUMBERS

Medicaid customer service: Please call the number on the back of the member's ID card for the most efficient call routing.

Prior authorization (PA) assistance for medical procedures: 1-800-523-0023 Monday – Friday, 8 a.m. – 8 p.m. Eastern time

Prior Authorization for medication billed as medical claim: 1-866-461-7273 Monday – Friday, 8 a.m. – 6 p.m. Eastern time

Prior Authorization for pharmacy drugs: 1-800-555-2546 Monday – Friday, 8 a.m. – 6 p.m. local time

Medicare/Medicaid case management: 1-800-322-2758

Medicare/Medicaid concurrent review: 1-800-322-2758

Clinical management program information: 1-800-491-4164

PrescribeIT: 1-800-526-1490

Availity customer service/tech support: 1-800-282-4548

Ethics and compliance concerns: 1-877-5 THE KEY (1-877-584-3539)

Healthy Behaviors are programs offered by Humana that encourage and reward behaviors designed to improve the enrollee's overall health. Programs administered by Humana must comply with all applicable laws, including fraud and abuse laws that fall within the purview of the United States Department of Health and Human Services, Office of Inspector General (OIG). The following Healthy Behaviors programs are offered to Humana members:

- **Baby Well Visit** — Member enrolls by calling 1-800-611-1467 and completing three well-baby visits before 18 months of age. They'll receive a \$10 gift card per visit, up to three after the provider claim is validated by Humana (up to three rewards totaling \$30).
- **Pediatric Well Visit** — Member enrolls annually by calling 1-800-611-1467 and completing a well-child visit. They'll receive a \$20 gift card after the provider claim is validated by Humana (up to one reward of \$20 per year).
- **Humana Fit** — Members 18 years and older can be self-, plan- or provider-referred by calling 1-855-330-8053. Once enrolled in the six-month program, members obtain baseline biometrics and medical clearance at an initial Primary Care Physician (PCP) visit. They'll receive a \$25 gift card with Humana's receipt of completed provider medical clearance/biometrics form. At program completion, members obtain a second biometric screening with their PCP, and they'll receive another \$25 gift card with Humana's receipt of completed provider medical clearance/biometrics form. Members also have the following incentives offered as members of the Fit program: a

personal health coach, six telephonic nutritional counseling sessions with a nutritionist/dietician, monthly newsletters covering a variety of topics related to weight management and healthy living, a weight scale and a walking kit (includes a step counter, a drawstring backpack, a water bottle and a towel). Members may receive up to two rewards of \$25 per year; up to one scale and walking kit per lifetime.

- **Mom’s First Prenatal and Postpartum** — Members can be self-, plan- or provider-referred by calling 1-800-322-2758, ext. 1500290 and completing all prenatal and postpartum visits with their provider; they’ll receive a \$30 gift card (up to one reward of \$30 per pregnancy).
- **Smoking Cessation** — Members 18 years and older can be self-, plan- or provider-referred by calling 1-800-221-5487. Once members complete the six-month program as smoke-free, they’ll receive a \$30 gift card. A second option available is for members who complete the six-month program as smoke-free with the use of a prescribed pharmacological agent will receive a \$50 gift card instead (up to one reward of \$30 per year for standard completion or up to one reward of \$50 per year for pharmacological completion).
- **Substance Abuse** — Members 18 years and older can be self-, plan- or provider-referred by calling Beacon Health Options at 1-800-221-5487. Members will receive a \$10 gift card for enrolling in the six-month program. Then at 90 days of sobriety, they receive a \$20 gift card. At 180 days of sobriety, they’ll receive another \$20 gift card and will complete the program (up to three rewards totaling \$50).

You can find these materials here: humana.com/provider/support/dinical/medicaid-materials/florida.

SECTION II – HUMANA LONG-TERM CARE

INTRODUCTION

Humana is a provider service network (PSN) and home health agency that provides services to our members in the most appropriate care setting. Our long-term-care managed care plan works directly with the state of Florida to provide our members with community and/or facility care with a focus to coordinate the member's primary care through his/her primary insurance. Humana is the only statewide contractor for this program, allowing our membership to freely move to any county they choose in the state.

Our first goal is to keep our members in their homes and provide home health care and community-based services that may delay or avoid long-term placement in a nursing facility. If our members need a more supervised environment or want more socialization, we will facilitate services in an assisted living facility or an adult family home. We understand that some of our members will require nursing home care; we will help members transition to this level of care when it is no longer safe to remain in a community setting. We facilitate care that meets the individual needs of each of our members.

The state of Florida's goals for this program are:

- Provide coordinated long-term care across different health care settings
- Ensure members' choice of the best long-term-care plan for their needs
- Create long-term-care plans with the ability to offer more services
- Provide access to cost-effective community-based long-term-care services

Humana has established guidelines to assist you in understanding the goals of our program. This handbook will provide you with vital information needed to develop and maintain an effective relationship as we work to meet members' needs.

STATEWIDE MEDICAID MANAGED CARE (SMMC)

The Statewide Medicaid Managed Care program is designed to care for all eligible individuals in a nursing home or a less restrictive environment in the community. Eligibility requirements are:

- 18 years of age or older
- Reside in the state of Florida
- Meet physical and financial requirements as determined by the state.

The Agency for Health Care Administration (AHCA) was required to change how some individuals receive health care from the Florida Medicaid program to implement this program. The changes to Florida Medicaid were made because of National Health Care Reform or the Affordable Care Act passed by the U.S. Congress.

There are two different components that make up Medicaid Managed Care:

- The Florida Long-term Care Managed Care program
- The Florida Managed Medical Assistance program

Medicaid recipients who qualify and become enrolled in the Florida Long-term Care Managed Care program will receive long-term care services through a long-term care managed care plan. Humana is the only contractor approved in all 11 regions of the state of Florida for the long-term-care program.

Medicaid recipients who qualify and become enrolled in the Florida Managed Medical Assistance program will receive all health care services other than long-term care through a managed care plan. All Humana Long-Term Care Plan members will be enrolled in one of the Medical Assistance managed care plans, and Humana will be responsible for coordinating long-term-care benefits with them as well as Medicare benefits if they are a dual eligible.

For more information on the Florida Long-term Care Managed Care program, please review the document “Florida Long-term Care Managed Care: Program Overview” at http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml.

LONG-TERM-CARE MANAGED CARE PROGRAM

Humana is proud to participate as a contractor for the state of Florida to operate a Medicaid-funded program known as the long-term-care managed care program. Medicaid is a program for eligible individuals and/or families with low incomes and resources. It is a means-tested program that is jointly funded by the state and federal governments and is managed by the state. Medicaid is the largest source of funding for medical and health-related services for people with limited income in the United States. People served by Medicaid must be U.S. citizens or legal permanent residents, and may include low-income adults, their children and people with certain disabilities. Poverty alone does not necessarily qualify someone for Medicaid.

The long-term-care managed care program is designed to care for all eligible individuals over the age of 18 who meet a level of care that requires nursing home care, as well as a financial criterion; both qualifications are determined by the state. The program provides eligible individuals with access to care in a nursing home or a less restrictive environment in the community. The program seeks to reduce the number of individuals residing in nursing homes so they may be cared for in less-restrictive environment while also creating cost savings for the state.

PRACTICE GUIDELINES

Humana has adopted practice guidelines that are incorporated in our policy and procedures, as well as our daily business practices.

Practice guideline requirements are designed with the following in mind:

- Guidelines must be based on valid and reliable clinical evidence or a consensus of health care professionals in the geriatric and disabilities fields.
- Guidelines are adopted based on the needs of the members.
- Guidelines are adopted after consultation with contracted health care professionals, when necessary.
- Guidelines are reviewed and updated periodically, as appropriate.
- Humana will disseminate the guidelines to all affected providers and, upon request, to members and potential members.
- Decisions for utilization management, member education, coverage of services and other areas to which these guidelines apply will be consistent throughout the policy and procedure manual and daily business practices.

MISSION STATEMENT

Our mission is to facilitate comprehensive, effective, cost-efficient health care and related services for our members through a community-based program tailored to the individual.

Core values:

H – Health

A – Advocacy

E – Ethics

C – Compassion

HOURS OF OPERATION

Our dedicated staff is available to answer questions between the hours of 8 a.m. to 8 p.m. Eastern time, Monday through Friday. If you have questions regarding services or benefits, please call the Provider Help Line at **1-888-998-7735**.

HUMANA LONG-TERM CARE PLAN WEBSITE – [Humana.com/Humanalongtermcare](https://www.humana.com/humanalongtermcare)

The Humana Long-Term Care Plan website is designed to give providers quick access to current provider and member information 24 hours a day, seven days a week. You will find also additional program and Humana Long-Term Care Plan information. Please contact your local provider contracting specialist if you have questions or concerns regarding the website.

CONFIDENTIALITY STATEMENT

Humana maintains a policy to ensure that medical records, claim information and grievances pertaining to members and providers remain confidential. The authorized release of information is used only for the resolution of medical problems or to enhance a member's health. Humana will ensure compliance with the Privacy and Security provisions of the Health Insurance Portability and Accountability Act (HIPAA).

ELIGIBILITY

Enrollment in Humana’s Long-Term Care Plan is based on standards of eligibility established by the Department of Elder Affairs (DOEA) and Comprehensive Assessment and Review for Long-term Care Services (CARES). Financial eligibility is based on standards of eligibility established by the Florida Department of Children and Families (DCF).

CONDITIONS OF ENROLLMENT

Recipients eligible for enrollment must:

- Be 18 years of age or older
- Reside in Florida
- Be determined by CARES to be at risk of nursing home placement, meet specific clinical criteria, and may be safely served with home and community-based services
- Be determined by DCF to be financially eligible. (Financial eligibility for the program is the same as the Medicaid Institutional Care program [ICP].)

For specific information regarding eligibility criteria, you may contact your provider contracting specialist or care management in your region.

MEDICAID PENDING

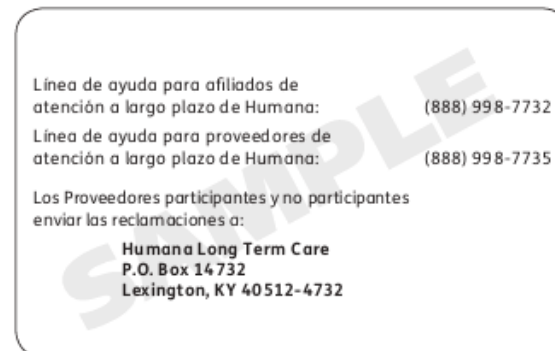
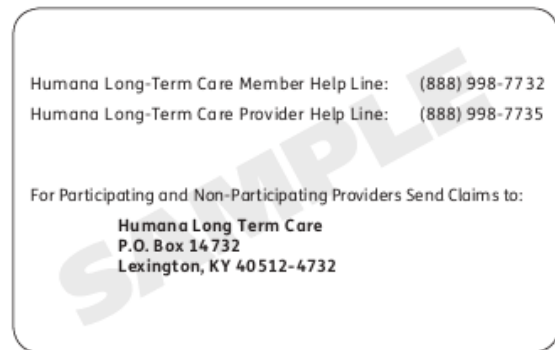
Individuals designated as “Medicaid pending” are those who have applied for the program and have been determined medically eligible by CARES, but have not been determined financially eligible for Medicaid by DCF.

Humana has elected to provide services to these individuals who reside in the community, and assist them with completing and returning applications to DCF. If DCF determines an individual is not financially eligible for Medicaid, Humana will terminate services and seek reimbursement from the individual who signed the financial agreement on the member’s behalf. The individual will receive an itemized bill for services received from the Humana Long-Term Care Plan during the ineligible span.

If a Medicaid-pending enrollee resides in a nursing home, the facility is required to assist with the Medicaid-pending process.

MEMBERSHIP IDENTIFICATION (ID) CARD

Each member receives a Humana Long-Term Care Plan member identification (ID) card. If the card is lost or stolen, the member may contact his or her care manager. English and Spanish sample member ID cards are below.



REFERRALS TO HUMANA LONG-TERM CARE PLAN

If an individual believes he or she may qualify to participate in the program, the individual or the individual's representative must contact the local Aging & Disability Resource Center (ADRC) office to apply for the Humana Long-Term Care Plan. As a provider, if you decide to assist the individual with the application process, you must obtain the individual's consent. To obtain the consent form, please visit <http://www.flmedicaidmanagedcare.com>. Choose the "Click Here to download the "Authorized Representative Form"" link at the top of the screen. The individual or the provider is welcome to contact Humana for program information at any time. To locate an ADRC office in your area, please refer to the Appendix.

MEMBER DISENROLLMENT

Disenrollment with cause

If a member is a mandatory enrollee and wants to change plans after the initial 90-day period ends or after the open enrollment period ends, the member must have a state-approved good-cause reason to change plans.

The Agency will review and determine approval of the member's request. More information is available from the enrollment broker by calling 1-877-711-3662.

The following are potential good-cause reasons to change managed care plans:

- The enrollee does not live in a region where the managed care plan is authorized to provide services, as indicated in the Florida Medicaid Management Information System (FMMIS).
- The provider is no longer with the managed care plan.
- The enrollee is excluded from enrollment.
- A substantiated marketing or community outreach violation has occurred.
- The enrollee is prevented from participating in the development of his/her treatment plan/plan of care.
- The enrollee has an active relationship with a provider who is not on the managed care plan's panel, but is on the panel of another managed care plan. "Active relationship" is defined as having received services from the provider within the six months preceding the disenrollment request.
- The enrollee is in the wrong managed care plan as determined by the agency.
- The managed care plan no longer participates in the region.
- The state has imposed intermediate sanctions upon the managed care plan, as specified in 42 CFR 438.702(a)(3).
- The enrollee needs related services to be performed concurrently, but not all related services are available within the managed care plan network, or the enrollee's primary care physician (PCP) has determined that receiving the services separately would subject the enrollee to unnecessary risk.
- The managed care plan does not, because of moral or religious objections, cover the service the enrollee seeks.
- The enrollee missed open enrollment due to a temporary loss of eligibility, defined as 60 days or less for LTC enrollees and 180 days or less for MMA enrollees.
- Other reasons per 42 CFR 438.56(d)(2) and s. 409.969(2), F.S., including, but not limited to, poor quality of care, lack of access to services covered under the contract, inordinate or inappropriate changes of PCPs, service access impairments due to significant changes in the geographic location of services, an unreasonable delay or denial of service, lack of access to providers experienced in dealing with the enrollee's health care needs, or fraudulent enrollment.

Some Medicaid recipients may change managed care plans whenever they choose, for any reason. To find out if a member may change plans, call the enrollment broker at 1-877-711-3662.

A member has the option to disenroll without cause

If a member must join a managed care plan and a member is subject to open enrollment, a member may ask to leave the managed care plan without cause. A member can submit this request to the agency or its enrollment broker. A member may disenroll from the Humana Long-Term Care Plan without cause in the following situations:

- During the 90 days following the enrollee's initial enrollment, or the date the agency or its agent sends the enrollee notice of the enrollment, whichever is later;
- At least every 12 months;

- If the temporary loss of Medicaid eligibility has caused the enrollee to miss the open enrollment period;
- When the agency or its agent grants the enrollee the right to terminate enrollment without cause (done on a case-by-case basis); or
- During the 30 days after the enrollee is referred for hospice services in order to enroll in another managed care plan to access the enrollee's choice of hospice provider.

COVERED SERVICES

Humana Long-Term Care Plan provides coverage for members who are enrolled in our long-term-care managed care program. Coverage is limited to those services authorized in writing by the member's care manager and in accordance with the Agency for Health Care Administration Medicaid Services Coverage and Limitations handbooks. Covered services include:

Adult companion care	Medical equipment and supplies
Adult day health care	Medication administration
Assistive care services	Medication management
Assisted living	Nutritional assessment/risk reduction services
Attendant care	Nursing facility services
Behavioral management	Personal care
Caregiver training	Personal emergency response system (PERS)
Care coordinator/case management	Respite care
Home accessibility adaptation services	Occupational therapy
Home delivered meals	Physical therapy
Home maker services	Respiratory therapy
Hospice	Speech therapy
Intermittent and skilled nursing	Transportation

MEDICALLY NECESSARY/MEDICAL NECESSITY

Medically necessary care or medical necessity is determined, as per 59G-1.010(166), Florida Administrative Code (FAC), as follows. "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
- Be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker or the provider.

“Medically necessary” or “medical necessity” for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service.

EMERGENCY SERVICE RESPONSIBILITIES

If a member requires emergency acute care services, contact the member’s primary insurance for precertification or send the member to the emergency room as deemed appropriate. Please contact the member’s assigned care manager or the Humana Long-Term Care Plan customer service department once the emergency is addressed. This will allow the care manager to follow up with coordinated care.

ADULT DAY CARE (ADC)

This service provides members with supervision, socialization and therapeutic activities in an outpatient setting. This also provides caregivers with respite. Meals are included as part of this service when the member is at the center during meal times. Adult day care health services include, but are not limited to, the following:

- Supervised, recreational activities at least 80 percent of the day
- Physical exercises
- Cognitive exercises
- Lunch and snacks
- Coordination of transportation
- Medication administration and management
- Vital signs monitoring
- Basic health monitoring, including glucose level checks
- Referral to physical therapy screening (conducted on-site)
- Hands-on assistance with personal care, such as toileting, eating, ambulating and grooming

ASSISTIVE CARE

Assistive care offers 24-hour services for members in assisted living facilities, adult family care homes and residential treatment facilities. Services include:

- 24-hour access to staff
- Assistance with ambulation
- Assistance with transferring
- Assistance with eating
- Dementia care
- Dressing and grooming
- Emergency/disaster plan
- Escort services
- Housekeeping
- Incontinence management
- Medication management
- Personal laundry and linen services
- Three meals per day, plus snacks
- Transportation
- Utilities
- Wander guard

ASSISTED LIVING FACILITY (ALF)

This service provides members with an alternative living arrangement where there is access to 24-hour staff in a “home-like” environment for members. Meals, personal care and housekeeping services are provided by the staff. The facility may be used for respite care. The community will provide members with the following services or as indicated in each individual provider contract:

- 24-hour access to staff
- Bathing assistance
- Medication management
- Three meals per day, plus snacks
- Incontinence management
- Incontinence supplies
- Nutritional supplements
- Housekeeping
- Personal laundry and linen service
- Utilities
- Transportation or coordination of transportation
- Alarmed doors or locked unit
- Personal hygiene items
- Escort to dining room

- Emergency/disaster plan
- Dementia care

Transportation – All Humana Long-Term Care Plan contracts with ALFs require the ALF to coordinate transportation for members. Humana Long-Term Care Plan members are eligible for transportation trips to long-term-care-covered services as authorized by Humana. Please contact the enrollee’s care manager for authorization approval. Our members will use their Medicaid gold card or their current acute Medicaid health plan ID card, respectively, for all trips to non-LTC-covered services (including emergency transportation).

BEHAVIORAL MANAGEMENT

This service provides behavioral health care services that help address mental health or substance abuse needs of long-term-care members. The services are used to maximize reduction of the member’s disability and restoration to the member’s best functional level.

HOME ACCESSIBILITY ADAPTATION SERVICES

These services provide members with home modifications that promote safety. This includes the installation of grab bars, ramps and widening of doors. These services exclude home modifications that may be considered home improvements. All services must be provided in accordance with applicable state and local building codes.

Members or caregivers will be contacted within two business days of receipt of authorization from the Humana Long-Term Care Plan care manager to schedule an appointment. Installation will take place within two weeks.

HOME-DELIVERED MEALS

This service provides nutritionally sound meals to members who are unable to shop or cook. Meals are delivered to the home hot, cold, frozen, dried or canned, with a satisfactory storage life. Each meal is designed to provide one-third of the Recommended Dietary Allowance (RDA). A signature must be obtained from the member or caregiver upon delivery of meals. Members coordinate changes to their meal delivery through their care manager.

HOME HEALTH CARE (HHC)

Providers contracted with the Humana Long-Term Care Plan must adhere to the following procedures when providing services:

- Humana reserves the right to determine the plan of care for its members, and will send a request of specific services and frequency in order to meet the member’s needs. Services may be provided in a member’s home or an assisted living facility on an hourly or per-visit fee as authorized by Humana. The HHC provider has a maximum of two hours to inform Humana Long-Term Care Plan staff if the requested services can be provided and the anticipated start date.

- HHC staff are required to have the agency's designated form signed by the member verifying that the services were provided at the time of each visit, including date/time of service and direct care staff who provided the service. **A copy of this form must be submitted to Humana when the claim is submitted.**
- If a Humana Long-Term Care Plan member is entitled to Medicare home health benefits, these benefits will be utilized prior to services being authorized under your contract with the Humana Long-Term Care Plan.

Home health services are authorized by the care manager on a weekly basis (Sunday through Saturday). Preauthorization is required by the care manager to provide services that exceed the number of hours authorized in a day or in a week. The only variation that is allowable without a preauthorization is to switch the days of services within the same week, with prior authorization of the member. If the schedule change is permanent, the provider should inform the care manager of the change.

Adult companion – Companions can perform tasks, such as meal preparation, laundry and shopping, while providing socialization for the member. This includes light housekeeping tasks incidental to the care and supervision of the member. Services do not include hands-on nursing care or bathing assistance.

Family training – This service provides training to family members in order to promote safety while caring for the member. This includes education regarding diabetes management, transferring an individual and how to use safety equipment properly.

Homemaker services – This service provides members with assistance with general household activities to include meal preparation, laundry and light housekeeping.

Occupational therapy – This service provides members with treatment to restore, improve or maintain impaired function in regard to daily living tasks (e.g., using a fork, using a shower chair or cooking from a wheelchair).

Personal care – This service provides members with assistance with bathing, dressing, eating, personal hygiene and other activities of daily living. A personal care worker can do incidental housekeeping, such as making beds and cleaning up areas where they have performed services.

Physical therapy – This service provides members with treatment to restore, improve or maintain impaired function in regard to ambulation and mobility such as walking, transferring or using a walker or wheelchair.

Respite care – This service provides caregivers with relief for short periods of time. Respite care may be provided by a home health agency, assisted living community or a skilled nursing facility. Respite care is not a substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist.

HOSPICE

This service provides forms of palliative medical care and services designed to meet the physical, social, psychological, emotional and spiritual needs of terminally ill members and their families. Care managers will coordinate this care with members enrolled in Medicare hospice services. If a member requires any hospice service traditionally covered by Medicaid, preauthorization is required from the care manager.

Members can be simultaneously enrolled in Humana Long-Term Care Plan and hospice. Medicaid hospice services require prior approval from Humana. Dual-eligible members may enroll in Medicare hospice. The care manager will assist to coordinate services. Members or their representatives are required to contact the Humana Long-Term Care Plan care manager before enrolling in a hospice program.

MEDICAL SUPPLIES (CONSUMABLE)

This service provides members and caregivers with supplies that assist in meeting members' needs. Items include incontinent supplies and diabetic supplies not covered by Medicare. These services do not include personal toiletries, over-the-counter medications or household items.

Consumable medical supplies include adult disposable diapers, tubes of ointment, cotton balls and alcohol for use of injections, medicated bandages, gauze and tape, colostomy and catheter supplies and other consumable supplies. Not included are supplies covered under home health service, personal toiletries and household items, such as detergents, bleach, paper towels or prescription drugs.

Services require written authorization from the Humana Long-Term Care Plan care manager. Supplies will be delivered to the member's home and the member or caregiver will sign an itemized receipt. Members must go through their care manager to make changes to an order. Nutritional supplements require both a physician's prescription and preauthorization from the Humana Long-Term Care Plan care manager. Members authorized to live in a contracted facility will receive this service directly from the facility.

MEDICAL SUPPLIES (DURABLE MEDICAL EQUIPMENT)

Durable medical equipment (DME) is medical equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful in the absence of illness or injury and is appropriate for use in the recipient's home. Medicare and Medicaid acute-care programs cover most DME that Humana Long-Term Care Plan members need. Items needed by Humana Long-Term Care Plan members that are not covered by Medicare require preauthorization from the Humana Long-Term Care Plan care manager.

SKILLED NURSING FACILITY (SNF) SERVICES

This service provides 24-hour assistance and nursing services for members when they can no longer remain in the community. Members must be evaluated by Humana Long-Term Care Plan staff to determine if they can be maintained in a less restrictive environment.

Skilled nursing facility services are coordinated with members' acute-care coverage. If members are dual eligible for Medicare and Medicaid, the Humana Long-Term Care Plan is responsible for coinsurance as per the Medicaid crossover guidelines. Claims must be submitted with the Medicare explanation of benefits (EOB).

The SNF staff is expected to inform Humana Long-Term Care Plan staff of changes or concerns identified while providing services to members to ensure that members' needs are being met.

- **Respite care** – Respite care provides caregivers with relief for short periods of time. Respite care may be provided by a SNF. Respite care is not a substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist.
- **Transportation** – All Humana Long-Term Care Plan contracts with SNFs require the SNF to coordinate transportation for our members. Humana Long-Term Care Plan members are eligible for transportation to long-term-care-covered services, as authorized by Humana. Please contact the member's care manager for authorization approval. Our members will use their Medicaid gold card or their current acute Medicaid health plan ID card, respectively, for all transportation trips to non-LTC-covered services (including emergency transportation).
- **Change in member's needs** – Providers will inform Humana Long-Term Care Plan staff of changes or concerns they identify while providing services to members in order to ensure that members' needs are being met. This includes notification of members being admitted to a hospital and/or going to a Medicare or Medicaid hospice program. Medicaid hospice services require preauthorization from Humana. Notification must be provided within 24 hours of a significant change in members' health care needs.
- **Custodial care** – All members requiring this service must be assessed and a determination must be made by Humana that the member no longer can live in a less restrictive setting. Members who receive approval for placement in a contracted skilled nursing facility for custodial care are required to pay the facility a patient responsibility amount based on their income, which is determined by the Department of Children and Families. Prior authorization is required by Humana.

NUTRITIONAL ASSESSMENT/RISK REDUCTION

This service provides members with an assessment, hands-on care and guidance for the caregiver and members with respect to nutrition. Nutritional assessments are provided by dietitians, usually from a home health agency. Humana reserves the right to determine the plan of care for its members and will send a request for specific services and frequency in order to meet members' needs. Services may be provided in members' homes or assisted living facilities on a 15-minute increment fee as authorized by Humana.

PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

This includes the installation and service of an electronic device that enables members at high risk of institutionalization to secure help in an emergency. The PERS is connected to the member's phone and programmed to signal a response center once a "help" button is activated. The member may also wear a portable "help" button to allow for mobility. PERS services generally are limited to those members who

live alone or are alone for a significant part of the day and who would otherwise require extensive supervision. Providers will train Humana Long-Term Care Plan members on the use and monthly testing of the unit upon installation and will notify Humana via telephone or fax if a member utilizes the system.

Providers are expected to install a medical alert system within five business days after receiving written authorization from a Humana Long-Term Care Plan care manager.

PHARMACY BENEFITS

The Humana Long-Term Care Plan provides a monthly \$15 over-the-counter (OTC) medication benefit for our members. This benefit is obtained through our mail-order pharmacy. Our OTC formulary is available upon request.

TRANSPORTATION

Humana Long-Term Care Plan members are eligible for transportation to long-term-care-covered services, as authorized by Humana. Please contact members' care managers for authorization approval. Our members will use their Medicaid gold card or their current acute Medicaid health plan card, respectively, for all transportation trips to non-LTC-covered services (including emergency transportation).

Transportation for nonmedical appointments can be provided for services but require preauthorization. Please contact the members' assigned care managers for more details.

QUALITY ENHANCEMENTS

Quality enhancement is education and/or community-based services that are coordinated by the care manager to address concerns related to safety in the home and fall prevention, disease management, education on end-of-life issues, advance directives and domestic violence.

CARE MANAGEMENT

The care management team provides assistance to members to help them live in the least restrictive environment that safely meets their long-term-care needs. If a member's needs cannot be met safely in a home or assisted living facility, the care manager will assist with placement and monitoring in a nursing home.

The care manager is responsible for developing an individualized plan of care that meets each member's needs in a safe environment. Long-term-care services and supplies must be preauthorized by the care management team before they can be provided to a Humana Long-Term Care Plan member. Contact the local care management team with requests for prior authorizations.

Care managers can assist members with:

- Assessments
- Coordination of care
- Authorization for services (See "Procedures for Authorization of Services")
- Change in services
- Discharge planning from inpatient services
- Transition between residential settings
- Eligibility (financial and level of care)
- Obtaining replacement ID card
- Concerns or questions about care

AUTHORIZATIONS

If a member needs services, a care manager will issue an authorization for covered services to a participating provider. Our care managers will assess members' needs prior to ordering services.

Procedures for authorization of services

- Upon determination that a member needs services from a facility or company, the care manager will contact the provider to inquire if the services can be provided. If yes, a new service request form will be faxed. A sample of this form can be found in the forms section of this handbook. The authorization is valid for the period of time specified or otherwise indicated on the authorization. If dates of services are not established, the provider's staff is responsible for following up with the care manager with the date that services will begin.
- If a member needs to stop services for a short period of time (e.g., due to a hospitalization), the care manager will fax a suspend/resume services request form. A sample of this form can be found in the forms section of this handbook.

- If a member no longer needs services from the provider, the care manager will fax a termination of services request form. A sample of this form can be found in the forms section of this handbook.
- If a member needs an increase or decrease in services, the care management team will fax a change of services request form. A sample of this form can be found in the forms section of this handbook.

If you have questions or concerns about a member, please contact our local care management team.

Chronic/complex conditions – The Humana Long-Term Care Plan covers services including, but not limited to, treatment for chronic and complex conditions. These services require preauthorization from a care manager. Humana Long-Term Care Plan staff helps coordinate those services with the member’s chosen provider. If the member requires a service that is covered by another insurer, the member will receive coverage for the service through that insurer.

If it is determined that there is a need for the service, a care manager will assist with care coordination. Service limitations include the following:

- Services must be preapproved.
- Services must be provided by an active provider in the Humana Long-Term Care Plan provider network.
- Services must be a covered benefit or an approved expanded benefit (see “Covered Services” below).
- Services must be medically necessary, as defined by 59G-1.01. (166), FAC:
 - Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
 - Be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
 - Be consistent with generally accepted professional medical standards as determined by the Medicaid program, not experimental or investigational;
 - Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and
 - Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker or the provider.

ABUSE, NEGLECT AND EXPLOITATION

Humana must notify government authorities if we suspect that one of our members is a victim of abuse, neglect or exploitation. Our network providers are expected to report incidents or concerns regarding our members.

Please report suspected cases of abuse, neglect and/or exploitation to Adult Protective Services by calling the toll-free number at 1-800-96ABUSE (1-800-962-2873). If you have questions, please call your local provider contracting specialist.

Humana requires all direct service providers who provide hands-on care to our members to attend and complete abuse, neglect and exploitation training. If you would like Humana Long-Term Care Plan staff to assist you in developing a program for your staff, please contact your local provider contracting specialist.

CRITICAL INCIDENT REPORTING

Critical incidents must be reported to Humana Long-Term Care Plan care management within 24 hours of the incident. A critical incident is defined as an adverse or critical event that negatively impacts the health, safety or welfare of a member. Critical incidents may include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing or major medication incidents. Assisted living facilities and skilled nursing facilities only need to report abuse, neglect or exploitation incidents to Humana. Critical incidents involving abuse, neglect or exploitation also must be reported by the provider to Adult Protective Services. Providers are expected to work with Humana Long-Term Care Plan staff to resolve all identified critical incidents in a timely manner and support the safety and well-being of our members.

MEMBER RIGHTS AND RESPONSIBILITIES

Care managers provide members with the following information at the time of enrollment and annually. Members have the right to:

- Be free from all forms of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion.
- Request and receive a copy of his or her medical records and request that they be amended or corrected, as per rules set forth in 45 CFR parts [160](#) and [164](#) subparts A and E, and as specified in 45 CFR § [164.524](#) and [164.526](#).

Members also have the right:

- To be fully informed in advance of all care and treatment to be provided by the service provider, changes in care or treatment and to receive a copy of their plan of care if they request.
- To be fully informed of services available from the service provider and how to access care.
- To be fully informed by a physician of health status, unless medically contraindicated.
- To be afforded the opportunity to participate in the development of the care plan and to refuse treatment without retribution, while being fully informed of the possible medical consequences of refusal.
- To be assured of the confidentiality of records and to approve or refuse the release of information not authorized by law.
- To be treated with consideration, respect, full recognition of dignity and individuality, including privacy in treatment and in care for personal needs; to have property treated with respect.
- To file a grievance without fear of discrimination or reprisal from the service provider.
- To be informed of the state hotline number with hours of operation and purpose for obtaining information on home health agencies.

- To be assured that qualified personnel will present proper identification at the time of a visit.
- To be served without regard to race, color, creed, sex, age, national origin, ancestry or handicap/disability.
- To be advised – before care is initiated – of the cost of services and the extent to which payment may be required by the patient.
- To receive home and community-based services in a home-like environment and participate in their communities regardless of their living arrangements.
- To direct their care with their own staff and/or providers.

Members have a responsibility:

- To provide accurate and complete medical and health history information as they understand it.
- To participate with the plan of treatment, when possible, and make available an informal caregiver to assume primary care, as appropriate.
- To have a primary care physician who will provide orders (as required) for skilled home-care treatments and services.
- To inform the service provider about changes in health status, medications or treatments.
- To inform the agency of any change in financial status that may affect reimbursement for home care.
- To have a plan for management of emergencies and to access the plan, if necessary for safety.
- To inform the service provider of the presence of advance directives and provide copies, as appropriate.
- To accept services of service provider staff, without regard to race, creed, color, religion, national origin, handicap, sex or age.
- To report fraud, abuse and overpayment.
 - To file a report of suspected fraud and/or abuse in Florida Medicaid:
 - Call the Consumer Complaint Hotline toll free at 1-888-419-3456
 - Call the Florida general hotline at 1-866-966-7226
 - Call the Special Investigations hotline at 1-877-217-9717
 - Complete a Medicaid fraud and abuse complaint form, which is available online at https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

If a member reports suspected fraud and the report results in a fine, penalty or forfeiture of property from a doctor or other health care provider, the member may be eligible for a reward through the Attorney General's Fraud Rewards Program. The reward may be up to 25 percent of the amount recovered, or a maximum of \$500,000 per case (Section 409.9203, Florida statutes). Individuals can talk to the Attorney General's Office about keeping their identity confidential and protected by calling toll free at 1-866-966-7226 or 1-850-414-3990.

PROVIDER RESPONSIBILITIES

The provider contracting department has designed this handbook to assist network providers with an overview of our operational policies and procedures. As a participating provider, you and your staff will have a dedicated provider contracting specialist who will be a key contact. Provider contracting specialists are responsible for ensuring services are available to our members by obtaining contracts and by providing ongoing community and provider training and education about the Humana Long-Term Care Plan. They also assist our network providers in understanding the terms of our contract and help resolve problems they may encounter.

You are encouraged to contact your provider contracting specialist when you have questions, comments or concerns. To locate your local provider contracting specialist, please call the provider hotline at 1-888-998-7735.

CREDENTIALING COMMITTEE

The credentialing committee has the responsibility to establish and adopt, as necessary, criteria for provider participation and termination. The committee also directs credentialing procedures, including provider participation, denial and termination. Committee meetings are held at least monthly and as deemed necessary. Failure of an applicant to adequately respond to a request for assistance may result in termination of the application process.

INITIAL CREDENTIALING

Providers seeking participation with the Humana Long-Term Care Plan must complete an application with required documentation and a signed contract. It is required that all providers maintain active status with licensure and insurance coverage and provide proper documentation annually as documents expire. It is required that Humana be immediately notified of changes in a provider's licensure, status of insurance coverage, disciplinary actions and/or ownership.

Humana Long-Term Care Plan's credentialing review includes, but is not limited to, the following criteria:

- Copy of current provider's medical license, or occupational or facility license as applicable to provider type, or authority to do business, including documentation of provider qualification as outlined by the governing agency
- No revocation, moratorium or suspension of license
- A satisfactory level II background check pursuant to guidelines for all treating providers not currently enrolled in Medicaid's fee-for-service program

- Medicaid ID number or Medicaid provider registration number for enrollment by state Medicaid program for compliance with data submission. (Humana will take the steps necessary to ensure that a provider's business is recognized by the state Medicaid program, including its enrollment broker, as a participating provider. It will also take the steps necessary to ensure that a provider's submission of encounter data is accepted by Florida's Medicaid Management Information System [MMIS] and/or the state's encounter data warehouse.)
- Certificate of insurance
 - Proof of general liability, professional liability (as applicable)
 - Proof of workers' compensation (as applicable)
 - Humana Long-Term Care Plan listed as notify agent or certificate holder on the certificate of insurance
- Licensure inspection/Agency for Health Care Administration (AHCA) survey as applicable
- W-9 indicating taxpayer identification number
- Disclosure of Ownership Addendum

Site visits – Site visits evaluate appearance, accessibility, recordkeeping practices and safety procedures. These visits are performed at assisted living facilities and adult family care homes to evaluate a home-like environment. Other site visits will be performed as deemed necessary.

RECREDENTIALING

Recredentialing is the process of reverifying the credentialing information of all providers previously credentialed. The purpose of this process is to identify changes in the provider's licensure, sanctions, certification, competence or health status, which may affect the ability to perform services under the contract. Each provider will be recredentialled at a minimum every three years. A notification will be sent to the provider for reverification of credentialing. All network providers must submit updated documents as they expire. Failure to provide updated documentation may delay payment. A provider's agreement may be terminated at any time if it is determined the credentialing requirements are no longer being met or the provider fails to complete the recredentialing process.

PROVIDER MONITORING

Humana will monitor providers routinely to ensure changes in licensure status, sanctions or other adverse actions are reviewed by the credentialing committee. Providers with suspended or revoked licenses are subject to termination.

RIGHT TO REVIEW AND CORRECT INFORMATION

All providers participating with the Humana Long-Term Care Plan have the right to review information obtained to evaluate their credentialing and/or recredentialing application. This includes information obtained from any outside primary source, such as the National Practitioner Data Bank, insurance carriers and other sources, as appropriate. This does not allow a provider to review references, recommendations or other information that is peer review-protected.

RIGHT TO APPEAL ADVERSE CREDENTIALING DETERMINATIONS

Providers who are declined participation have the right to request a reconsideration of the decision in writing within 14 days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in Humana Long-Term Care Plan's network. Reconsiderations will be reviewed by the credentialing committee at the next regularly scheduled meeting, but in no case later than 60 days from the receipt of the additional documentation. The applicant will be sent a written response to the request within two weeks of the final decision.

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI is a unique government-issued standard 10-digit identifier mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Humana requires that participating providers comply with this mandate, as appropriate. Please refer to the Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov for additional information and assistance with applying for an NPI.

PROVIDER ORIENTATION AND EDUCATION

Your provider contracting specialist is available to provide an initial orientation within 30 calendar days of completion of the credentialing process. This orientation reviews Humana Long-Term Care Plan policies and procedures. These personalized meetings are scheduled at your convenience, including staff you would like to attend. Additional educational trainings can be scheduled anytime by contacting your local provider contracting specialist.

NOTICE OBLIGATION

The network provider is responsible for giving the appropriate notices as outlined in this provider handbook and under the terms of your contract with Humana.

- **Changes in your office** – Notify your provider contracting specialist immediately of changes in your office, such as:
 - Physical address change
 - Tax identification/billing address change (W-9 required)
 - Demographic changes (e.g., telephone, fax, email or administrative staff changes)
 - New patient indicator
 - Name and ownership change (35-day notice)

This notification will ensure your information is properly listed in the provider directory and all payments made are properly reported to the Internal Revenue Service. A provider notice of change form is located in the forms section of this handbook. Failure to comply with this section could lead to a delay in payments.

Providing covered services – In the event there are changes in your office that will affect your company's ability to provide services to Humana Long-Term Care Plan members, please notify the provider contracting department immediately.

PROVIDER DIRECTORY

The provider directory is a weekly listing of all participating network providers with the Humana Long-Term Care Plan. A copy of this document is available upon request from the provider contracting department. You can also access the provider directory on our website at [Humana.com/Humanalongtermcare](https://www.humana.com/Humanalongtermcare).

PARTICIPATING AGREEMENT STANDARDS

By signing a Humana Long-Term Care Plan contract, providers are required to comply with all applicable federal and state laws and licensing requirements. Providers are required to maintain back-up procedures for absent employees to ensure services are not interrupted. Humana may exercise its options to terminate a participating provider from the provider network with the appropriate notice.

ACCESSIBILITY AND AVAILABILITY

Humana has adopted service standards regarding the availability of participating provider services. All providers are expected to maintain these standards as outlined in your contract.

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

PROVIDER SATISFACTION SURVEY

Humana conducts an annual provider satisfaction survey that includes questions to evaluate provider satisfaction with our services, such as claims, communications, utilization management and provider services. Providers are randomly selected and are kept anonymous. We encourage you to participate and respond to the survey as the results are analyzed and used to develop provider-related quality improvement initiatives.

PROVIDER MEDICAL/CASE RECORD REVIEW

- Humana Long-Term Care Plan staff will conduct reviews at the following provider and facility provider sites every other year:
 - Adult family care homes
 - Assisted living facilities
- For service providers with multiple office locations, staff will conduct reviews at each practice site at least every three years.
- Specific review tools applicable to each type of provider will be shared with the provider and utilized to conduct the reviews after establishment of inter-rater reliability.
- A minimum of five records or 5 percent of the member census (whichever is greater) will be reviewed per site. The cases will be selected randomly and be evaluated for compliance with meeting medical/case record review standards established by nationally recognized accrediting bodies.

- Medical record confidentiality will be maintained by use of patient ID numbers and records will not be removed from the provider or facility provider location for security reasons.
- After each provider review is complete, the data will be submitted to the corporate quality improvement department where it will be analyzed, aggregated and compared.
- On a quarterly basis, the Q/I department will report the results of the record reviews to the senior management team and the provider contracting department. The department will also make recommendations for further action, if indicated.

TERMINATION OF PROVIDER CONTRACT

Each provider has the right to terminate his/her contract with Humana Long-Term Care Plan. You must submit your request in writing and provide 90 days of notice. All termination requests need to be mailed to:

Humana Long-Term Care Plan
Attention: Provider Contracting Department
14565 Sims Road
Delray Beach, FL 33484

OUT-OF-NETWORK/NONCONTRACTED SERVICES

An out-of-network provider is a provider who is not directly contracted with the Humana Long-Term Care Plan. The Humana Long-Term Care Plan is not responsible for payment of services provided by an out-of-network provider without written prior authorization.

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

Humana Long-Term Care Plan is not responsible for payments of services ordered by a member from a participating provider, without written preauthorization from a Humana Long-Term Care Plan care manager. Please contact the member's assigned care manager to request authorization prior to providing services.

COMMUNITY OUTREACH/MARKETING

All providers must comply with the following standards regarding outreach marketing activities in their office or at sponsored events:

- Providers **may** display health plan-specific materials in their own offices.
- Providers **cannot** orally or in writing compare benefits or provider networks among plans, other than to confirm whether they participate in a plan's network.

- Providers **may** announce a new affiliation with health plan and include it on a list given to their patients with plans with which they contract.
- Health care providers **may** co-sponsor events, such as health fairs, and advertise in indirect ways, such as television, radio, posters, fliers and print advertisement.
- Providers **may not** furnish lists of their Medicaid patients to another plan with which they contract, or any other entity, nor can providers furnish other health plans' membership lists to the health plan, nor can providers take applications in their office.
- Providers **may** distribute information about nonhealth-plan-specific health care services and the provision of health, welfare and social services by the state of Florida or local communities, as long as inquiries from prospective members are referred to member services or the Agency enrollment broker.

The use of the Humana Long-Term Care Plan name requires written notice prior to use in television, radio, posters, fliers and print advertisement.

PROVIDER RESPONSIBILITIES

The provider must adhere to the following responsibilities:

- Provide all services in a culturally competent manner, accommodate those with disabilities and do not discriminate against anyone based on his or her health status.
- Treat all members with respect and dignity; provide them with appropriate privacy and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release.
- Maintain a safe environment and comply with city, state and federal regulations concerning safety and public hygiene.
- Ensure accessibility and availability of services to members.
- Participate and cooperate in quality management, utilization review and continuing education with other similar programs to provide care in a responsible and cost-effective manner.
- Participate in and cooperate with grievance procedures when notified of a member complaint or grievance.
- Comply with all applicable federal and state laws regarding the confidentiality of member records.
- Maintain communication with the appropriate agencies to provide member care.
- Ensure enrollment or registration by state Medicaid program for compliance with data submission.

Providers contracted with the Humana Long-Term Care Plan should refer to their contracts for complete information regarding providers' responsibilities and obligations. Failure to comply could result in contract termination.

PROVIDER COMPLAINT SYSTEM

Providers have the right to register a provider complaint involving a dispute with Humana Long-Term Care Plan policies, procedures or an aspect of the plan's administrative function. Every effort will be made to resolve the issue informally. In the event the issue cannot be resolved informally, a complaint may be filed telephonically at 1-888-998-7735. You also can submit the complaint in writing by mailing to the provider contracting department at:

Humana Long-Term Care Plan
ATTN: Provider Contracting – Provider Complaint
14565 Sims Road
Delray Beach, FL 33484

Provider Complaint Review – Upon receipt of a complaint, Humana will thoroughly investigate each complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the plan's written policies and procedures. A provider complaint may be filed using the following steps:

- Verbal complaint:
 - A provider contracting specialist or call center representative will receive the initial call and attempt to resolve the issue(s) or concern(s) at the time of the call.
 - All nonclaims complaints will be acknowledged in writing within three business days of the initial call. The provider will be notified verbally or in writing that the complaint was received and the expected date of resolution. The provider will be notified in writing regarding the status of the inquiry within 15 calendar days of receipt of the initial complaint and receive a letter every 15 days until the complaint is resolved.
 - It is anticipated that all complaints will be resolved within 90 days. A disposition letter will be sent for all complaints (claims and nonclaims).
- Written complaint:
 - The provider will complete a provider complaint form (see the forms section in this handbook) and fax or mail the completed form to Humana Long-Term Care Plan.
 - All nonclaims complaints will be acknowledged within three business days of the initial call. The provider will be notified verbally or in writing that the complaint was received and the expected date of resolution. The provider will be notified in writing regarding the status of the inquiry within 15 calendar days of receipt of the initial complaint and receive a letter every 15 days until the complaint is resolved.
 - It is anticipated that all complaints will be resolved within 90 days. A disposition letter will be sent for all complaints (claims and nonclaims).

The provider has 45 calendar days to file a written complaint for issues that are not related to claims.

CULTURAL COMPETENCY

Humana expects that our members will receive understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and in their preferred language. Humana encourages participatory and collaborative partnerships with communities to be utilized in a variety of formal and informal mechanisms to facilitate community and member involvement in designing and implementing culturally and linguistically appropriate services. Humana Long-Term Care Plan staff will coordinate language assistance for members who have limited English proficiency.

Providers may access the full cultural competency plan on our website or you can request a hard copy of the cultural competency plan at no charge by contacting your provider contracting representative.

COMPLIANCE/ETHICS

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. The most current version of the provider handbook is available on Humana's Long-Term Care Plan website.

Humana's policies and procedures incorporate requirements outlined by CMS for all sponsors of Medicare Advantage or prescription drug benefit plans and 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 fraud, waste and abuse (FWA) requirements for contracted providers, regardless of their participation in a Humana Medicare plan, include, but are not limited to:

- Being familiar with Humana's compliance expectations and requirements relating to FWA, which have been outlined in this provider handbook.
- Monitoring the compliance of employees.
- Monitoring and auditing the compliance of subcontractors that provide services or support related to administrative or health care services provided to a Humana Long-Term Care Plan member or a member of a Humana Medicare Advantage or prescription drug plan (downstream entities).
- Obtaining approval from Humana for relationships with downstream entities. In addition, note that Humana must notify CMS of locations outside of the United States or a United States territory that receive, process, transfer, store or access member protected health information in oral, written or electronic form.
- Reporting instances of suspected and/or detected FWA.
- Having policies and procedures in place for preventing, detecting, correcting and reporting FWA, including, but not limited to:
 - Requiring employees and downstream entities to report suspected and/or detected FWA;
 - Safeguarding Humana's confidential and proprietary information;
 - Providing accurate and timely information/data in the regular course of business; and

- 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 Long-Term Care Plan, and Humana must be notified immediately upon such identification.)
- Cooperating fully with all investigations of alleged, suspected or detected violations of the handbook, Humana Long-Term Care Plan policies and procedures or applicable state or federal laws or regulations and/or remedial actions.
- Administering compliance and FWA training to employees and downstream entities including, but not limited to:
 - Documenting that training requirements have been met; and
 - Having a system in place to collect and maintain records of compliance and FWA training for a period of at least 11 years.
- Instituting disciplinary standards and taking appropriate action upon discovery of FWA or actions likely to lead to FWA.
- Publicizing disciplinary standards to employees and downstream entities.
- Avoiding conflicts of interest and providing Humana with conflict of interest statements covering the provider, employees and downstream entities.

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 efforts to prevent and detect fraud can be found on Humana's website at <http://www.humana.com/about/fraud>, and in Humana's Ethics Everyday for Contracted Health Care Providers and Business Partners, compliance policy and FWA training, in addition to the Humana Long-Term Care Plan provider handbook.

Providers, their employees and downstream entities may report concerns and information related to FWA and noncompliance with this provider handbook, Humana's Ethics Everyday for Contracted Health Care Providers and Business Partners and compliance policy to Humana via a number of anonymous options:

- By calling Humana's Special Investigations voice messaging system at 1-800-614-4126 (24/7 access)
- By calling Humana's Ethics Help Line at 1-877-5-THE-KEY (1-877-584-3539)
- By emailing siureferrals@humana.com or ethics@humana.com

Humana can be contacted directly by calling Humana's Special Investigations Hotline at 1-877-217-9717.

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 nonretaliation 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 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 an unforeseen complication or unusual event in which a Humana Long-Term Care Plan member or member of a Humana health plan is involved. 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 a provider's office or facilities;
- 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 (Please 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:
 - 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)
 - Drug, treatment or service prescribed

Providers are expected to report an occurrence that happens to a member when visiting, except those 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 immediately. Occurrence reports for Humana Long-Term Care Plan members can be reported to:

- Humana Long-Term Care Plan Care Management Team
- Humana Long-Term Care Plan Provider Contracting hotline at 1-888-998-7735
- Humana Long-Term Care Plan Special Investigations Hotline at 1-877-217-9717

Note: Occurrences must be received by Humana America Eldercare and reported to AHCA within 24 hours of the occurrence. The information submitted to Humana is used for state-mandated risk management review. All information reported to Humana 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 a Humana associate, representative or customer or government official in connection with Humana procurement, transaction or business dealing. This prohibition also applies to 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 conflict of interest that would prevent them from administering or delivering Medicaid 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 financial relationships 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 a 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.

FRAUD, WASTE AND ABUSE

Humana has policies and procedures in place for the detection and reporting of fraud, waste and abuse.

Definitions of fraud, waste and abuse

- **Fraud** is an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes all acts that constitute fraud under applicable federal or state law.
- **Waste** generally means over-use of services or other practices that result in unnecessary costs. In most cases, waste is not considered caused by reckless actions but rather the misuse of resources.
- **Abuse** includes: (1) Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; (2) Recipient practices that result in unnecessary cost to the Medicaid program.

Examples of fraud, waste and abuse

Some examples of fraud, waste and abuse include:

- Billing for services not furnished.
- Double billing and/or clustering
- Soliciting, offering or receiving a kickback, bribe or rebate
- Identity theft
- Members sharing their ID cards with friends and/or relatives for use
- Billing for more expensive services or procedures than were actually provided
- Charging in excess for services and supplies or items not covered as if they were covered
- Performing tests on a member to establish medical necessity
- Upcoding the level of service provided or unbundling services
- Seeking reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care
- Prescribing a medication for 30 days with a refill when it is not known if the medication will be needed, let alone for up to 30 days or more

Detection of fraud, waste and abuse

Humana uses the following mechanisms to prevent or detect potential fraud, waste and abuse:

- Trending of provider complaints, billing patterns, payment history, acute care, emergency room and pharmacy claims
- Ad hoc reporting, custom analyses, specialty profiling and outlier detection
- Claim check editing that identifies lifetime procedures, duplicate payments and payment to specific procedure codes to gender and age
- Confirming that providers, employees and subcontractors are not included on the federal and state exclusion lists

- Utilizing the member/provider hotline to report fraud, waste and abuse
- Payment review methodologies to detect suspicious cases to include upcoding, bundling/unbundling and utilization patterns
- Direct reporting to the special investigations unit from staff, members or providers and state and federal agencies

Special Investigations Unit

The Special Investigations Unit's primary responsibility is to coordinate the prevention, detection, investigation, recovery and reporting of cases of suspected fraud, waste and abuse. All allegations of fraud, waste and abuse will be reported to the Special Investigations Unit and thoroughly investigated. All suspected or confirmed instances of internal and external fraud and abuse relating to the provision of, and payment for, Medicaid services including, but not limited to, Humana employees/management, providers, subcontractors, vendors, delegated entities or enrollees under state and/or federal law, will be reported to Medicaid Program Integrity (MPI) within 15 calendar days of detection.

The Special Investigations Unit receives allegations of fraud, waste and abuse from multiple sources, including members, providers and internal staff. Upon receipt of an allegation of fraud, waste or abuse, the Special Investigations Unit may request that subsequent provider claims be pended and may require a review of records before the claims will be approved for payment. The Special Investigations Unit is dedicated to the detection of fraud, waste and abuse, and committed to reporting all fraud.

Individuals' responsibilities relating to detection and prevention

All managed care plans and their employees, subcontractors, vendors, providers and enrollees are required to report suspicious activities related to the provision of and payment for Medicaid services. Individuals should be committed to the detection and prevention of fraud, waste and abuse. It is important that individuals are aware of the examples of fraud, waste and abuse and that individuals pay attention to suspicious activities. All activities considered potentially fraudulent must be reported immediately via one of the methods set forth below. Not making a report when having knowledge of possible inappropriate actions or plans can lead to disciplinary action.

Ways to report suspected wrongdoing, including fraud, waste or abuse, pertaining to Florida Medicaid

- Call the Consumer Complaint Hotline at 1-888-419-3456
- Call the Florida Attorney General Hotline at 1-866-966-7226
- Call the Humana Long-Term Care Plan Special Investigations Hotline at 1-877-217-9717
- Complete a Medicaid fraud and abuse complaint form, available online at:

https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

Protections for those making reports

Humana strictly prohibits intimidation and/or retaliation against any employee, subcontractor, vendor, provider or enrollee who, in good faith:

- Reports an actual or suspected violation of ethical standards, Humana policies or procedures and applicable laws, rules or regulations; or
- Participates in the investigation of a suspected or detected violation.

Please also refer to the whistleblower protection provision outlined in the FEDERAL AND STATE LAWS AND REGULATIONS section.

CLAIMS/BILLING

Humana maintains and complies with HIPAA standards for the submission and adjudication of claims. This section will provide information regarding the submission and payment process.

CLAIM SUBMISSION

A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 CFR 447.45.

All claims should be submitted to the Humana Long-Term Care Plan within six months from the date of service, discharge from an inpatient setting or the date that the provider was furnished with the correct name and address of the managed care plan. When the Managed Care Plan is the secondary payer and the primary payer is an entity other than Medicare, the Managed Care Plan shall require the provider to submit the claim to the Managed Care Plan within ninety (90) days after the final determination of the primary payer, in accordance with the Medicaid Provider General Handbook. When the Managed Care Plan is the secondary payer and the primary payer is Medicare, the Managed Care Plan shall require the provider to submit the claim to the Managed Care Plan in accordance with timelines established in the Medicaid Provider General Handbook. The Managed Care Plan shall not deny Medicare crossover claims solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three (3) years. Humana Long-Term Care Plan shall not deny claims submitted by a nonparticipating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds 365 days. Claims that are incomplete, illegible or missing identifiable information may delay payment or could result in a denial of payment. For more information on claim submission, please visit our website at [Humana.com/Humanalongtermcare](https://www.humana.com/Humanalongtermcare).

ELECTRONIC CLAIMS

Humana Long-Term Care Plan is capable of receiving electronic claims submission. The acceptable formats include X12 5010 837 institutional, professional and dental formats. Humana Long-Term Care Plan also allows for direct data entry (DDE) through www.availity.com

For questions on how to enroll in electronic claims submissions, please contact:

- Email: communityoutreach@humana.com
- Phone: 1-561-665-4415

PAPER CLAIMS

Please submit claims on one of the following claim form types:

- Form CMS-1500 (adult day care, assisted living facility, home health provider, home-delivered meals provider, consumable medical supplies providers, environmental adaptation providers)
- Form UB-04 (skilled nursing facility and hospice)

Please make sure that the description of services listed on your claim form matches the service requests authorization document forwarded by the care manager.

To avoid a delay in processing your claims, please include the following information on claims:

- Member name (last, first)
- Member date of birth
- Member address
- Provider information (provider's name, address and tax identification)
- Provider signature
- Description of service and code provided
- Service/procedure/Healthcare Common Procedure Coding System (HCPCS) code
- Date(s) of service
- Units of service (amount of services provided or quantity of items provided)
- Total number of units billed and total dollar amount billed
- Total amount of service hours provided or quantity of items provided
- Humana Long-Term Care Plan member ID or Medicaid ID, if available
- Plan identification
- ICD-10 code

When submitting on a UB-04 form, use the correct "type of bill" codes:

Type of bill codes for nursing facility provider type #9 (hospital-based skilled unit) and #10 (nursing facility)		
0211	Admit-through-discharge Claim	One claim for an entire stay Date of admission: the same as the first date of service Date of discharge: the same as the last date of service
0212	Interim – First Claim	First claim for continued stay Date of admission: a date prior to the first date of service Date of discharge: none, continued to reside in facility
0213	Interim – Continuing Claim	Interim claim for a continued stay Date of admission: a date prior to the first date of service Date of discharge: none, continued to reside in facility
0214	Interim – Last Claim	Last claim for continued stay Date of admission: a date prior to the first date of service Date of discharge: the same as the date of service
0215	Late-charges-only Claim	Dates of service billed are after the date of discharge billed on a previous claim TOB 0211 (entire stay) or 0214 (last claim). Florida Medicaid does not require the use of 0215.

0217	Replacement (Adjustment) of Prior Claim	Completely replaces a previous paid claim; the original bill is considered null and void
0218	Void/Cancel of a Prior Claim	Eliminates and cancels a previous paid claim
Type of bill codes for nursing facility provider type #13 (rural hospital swing bed)		
0281	Admit-through-discharge Claim	One claim for an entire stay Date of admission: the same as the first date of service Date of discharge: the same as the last date of service
0282	Interim – First claim	First claim for continued stay Date of admission: a date prior to the first date of service Date of discharge: not the same as the last date of service
0283	Interim – Continuing Claim	Interim claim for a continued stay Date of admission: a date prior to the first date of service Date of discharge: not the same as the last date of service
0284	Interim – Last Claim	Last claim for continued stay Date of admission: a date prior to the first date of service Date of discharge: not the same as the last date of service
0285	Late-charges-only Claim	When dates of service after the date of discharge billed on a previous claim with TOB 0281 (entire stay) or 0284 (last claim)
0287	Replacement of Prior Claim	Completely replaces a previous claim; the original bill is considered null and void
0288	Void/Cancel of a Prior Claim	Eliminates and cancels a previous paid claim
Hospice care agency		
0813	Hospice Original Claims	
0817	Hospice Replacement of Prior Claims (Adjustment)	
0818	Hospice Void	

Mail paper claims to the following address:

Humana Long-Term Care Plan
Attn: Claims Department
P.O. Box 14732
Lexington, KY 40512-4732

If you have questions or would like training regarding submitting claims, please contact your local provider contracting specialist.

ENCOUNTER DATA

Humana Long-Term Care Plan is authorized to take the necessary steps to ensure that providers are recognized by the state Medicaid program, including its enrollment broker contractor(s), as a participating provider of the plan, and that your submission of encounter data are accepted by the Florida MMIS and/or the state's encounter data warehouse.

Protocols for submitting encounter data:

- All providers and any provider who has services directly paid by Humana Long-Term Care Plan and bills Humana Long-Term Care Plan via paper claims (e.g., CMS-1500 or UB-04) or electronically need to ensure that all the required fields are completed in the submission so that Humana Long-Term Care Plan can extract the encounter data information.
- Required fields for claims submissions can be reviewed in the Humana Long-Term Care Plan companion guide.
- For more information on claim submissions, please visit our website at **Humana.com/Humanalongtermcare**.
- If you have questions about what is required of your agency/company, please contact your provider contracting specialist or call provider customer service at 1-888-998-7735.

ASSISTED LIVING FACILITY PROVIDERS

Room and board rate—Members are responsible for paying the room and board rate (as indicated in the provider's contract), plus patient responsibility (as determined by the DCF). Prorated fees will be determined for members who do not reside in the community for a full month. Humana Long-Term Care Plan will be responsible for payment using the following formula:

Contracted ALF rate minus room and board rate minus patient responsibility = Humana payment

These amounts will be reflected on each member's individual service requests sent by a care manager. The patient responsibility is subject to change based on the Notice of Case Action (NOCA) received by DCF or estimated member responsibility until the appropriate NOCA is completed. Humana Long-Term Care Plan staff will complete routine audits to ensure patient responsibility is being collected by the facility.

The provider is required to notify Humana Long-Term Care Plan within 24 hours of a member hospitalization or leave of absence from the community.

Bed-hold payments—Humana Long-Term Care Plan will pay up to 21 days of bed hold when our member is not in your community, except in the following occurrences:

- Member loses Medicaid eligibility
- Member expires
- Member is placed in a skilled nursing facility for long-term care
- The community fails to notify Humana Long-Term Care Plan within 24 hours of a hospitalization or leave of absence from the community

Prorated fees will be determined for members who reside in a facility for less than a full month.

Bed holds **or** stop payment begins the day the member leaves the facility. The facility will not be paid for the day of discharge **unless** the member is eligible for a bed hold. If the facility fails to notify Humana Long-Term Care Plan of a member leaving the community within 24 hours of discharge, it will result in a forfeit of payment for the bed hold. The facility may not charge the member for Humana Long-Term Care Plan's portion of their bill during this time.

SKILLED NURSING FACILITY (SNF) PROVIDERS

Custodial care – All members requiring custodial care must be assessed and a determination must be made by Humana Long-Term Care Plan that the member can no longer live in a less restrictive setting. Members who receive approval for placement in a contracted SNF for custodial care are required to pay the facility a patient responsibility based on their income, which is determined by the DCF. **Prior authorization is required.**

Custodial care payments – The facility will be reimbursed by Humana Long-Term Care Plan at the current Medicaid per-diem rate established with the state minus patient responsibility determined by the DCF.

Bed holds for skilled nursing facilities – Humana Long-Term Care Plan pays to reserve a bed for a maximum of eight days for each hospital stay. One day is defined as an overnight stay away from the nursing facility.

Bed holds for therapeutic beds – Humana Long-Term Care Plan pays the skilled nursing facility to reserve a residence bed in order for a resident to go to a family-type setting for a maximum of 16 days per each state fiscal year. One day is defined as an overnight stay away from the skilled nursing facility.

Bed holds for custodial care members – Humana Long-Term Care Plan follows the same guidelines as Medicaid. If your facility is requesting payment for a bed hold on a Humana Long-Term Care Plan member, please submit a copy of your census along with your claim for the time frame in question.

HOME HEALTH PROVIDERS

It is recommended that services are not billed in a date range format. Each service should be listed separately by date of service.

PAYMENTS

Humana Long-Term Care Plan will issue paper checks or electronic funds transfer (EFT). If providers do not elect EFT, paper checks will be mailed to the address on file at Humana Long-Term Care Plan. If providers enroll on Availity.com and elect EFT, electronic funds will be utilized. Humana recommends that providers elect EFT for the following reasons:

- Eliminates the risk of checks lost in the mail and reduces the potential for fraud
- Reduces provider administrative burden associated with handling paper checks

Providers can sign up for EFT via www.availity.com.

Hard copy checks – All claim payments made by Humana Long-Term Care Plan to a provider will be accompanied by an explanation of payment. The explanation of payment will contain an itemized accounting of the individual claims included in the payment including the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement and the identification of Humana. The date of the check also will be included on the explanation of payment. The date of the check will be considered the date of payment. Providers also may view claim status via the Web portal.

Electronic funds transfer (EFT) – If claims payments are made by Humana Long-Term Care Plan via EFT, the explanation of payments will be available through Availity.com.

BALANCE BILLING

Payments made by or processed through Humana Long-Term Care Plan are in accordance with the terms of your agreement with Humana Long-Term Care Plan. Providers may not balance bill members of Humana Long-Term Care Plan for covered, authorized services as per your agreement with Humana Long-Term Care Plan.

CLAIM INQUIRY

Providers are encouraged to contact the customer service department to inquire about the status of a claim, status of reconsideration or explanation of a denial. A customer service representative can be reached by calling 1-888-998-7735. Hours of operation are 8 a.m. to 8 p.m., Monday through Friday. If you are calling after hours, please leave a message and a representative will return your call within one business day.

CLAIM DENIALS

All denials include an explanation of denial and/or explanation of adjustment when applicable. Denial codes are subject to change and/or additional codes may be utilized. Please contact the claims customer service department at 1-888-998-7735 with questions or concerns regarding a denial or partial denial of payment. A copy of denial codes performed by Humana Long-Term Care Plan and descriptions of denial codes can be found in the appendix.

Humana Long-Term Care Plan will not deny Medicare crossover claims solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three years. A copy of denial codes performed by the Medicaid Fiscal Agent may be found in the applicable Medicaid General Provider Reimbursement Handbook. If you disagree with a denial received, you have the right to reconsideration.

CLAIM RECONSIDERATION OF PAYMENT

A provider has the right to request reconsideration if he or she does not believe the determination on a claim is correct. Parties not involved in the initial determination will review the reconsideration. All reconsiderations should be submitted in writing within 12 months of the last processed date of the denial notice and include additional information needed.

Claims reconsideration of payment should be mailed to the following address:

Humana Long-Term Care Plan
Attn: Claims Department (Reconsiderations)
P.O. Box 14732
Lexington, KY 40512-4732

FEDERAL AND STATE LAWS AND REGULATIONS

Filing false claims – Numerous federal and state laws prohibit health care providers from submitting false or fraudulent claims to Medicare and Medicaid and other federally funded health care programs. Presented below is a listing of various federal and state statutes related to fraud and abuse. All employees, providers, subcontractors, vendors, delegated entities and enrollees are required to comply with the following laws at all times:

- Social Security Act, ss. 1128, 1902, 1903, and 1932; 42 CFR 431, 433, 434, 435, 438, 441, 447, 455;
- 45 CFR Part 74;
- Chapter 68.081-68.09, F.S.;
- Chapters 409, 414, 458, 459, 460, 461, 626, 641 and 932, F.S.; and,
- 59A-12.0073, 59G and 69D-2, F.A.C.

Florida False Claims Act, 68.081-68.09, F.S. – The Florida False Claims Act imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from Medicaid or state programs. The penalty for filing a false claim is a minimum of \$5,500 and not more than \$11,000 per claim and treble damages (recoverable damages three times the value of the amount falsely received). In addition, the false claims filer may have to pay the governments' legal fees. The False Claims Act allows private individuals to file lawsuits in state court, just as if they were state prosecutors. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25 to 30 percent of the proceeds if the government did not participate in the suit, or 15 to 25 percent if the government did participate in the suit.

False Claims Act, 31 U.S.C. 3729-3733 – The federal False Claims Act imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from Medicare, Medicaid or other federal health programs. The penalty for filing a false claim is a minimum of \$5,000 and not more than \$10,000 per claim and treble damages (recoverable damages three times the value of the amount falsely received). In addition, the false claims filer may have to pay the governments' legal fees. The False Claims Act allows private individuals to file lawsuits in federal court, just as if they were federal prosecutors. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25 to 30 percent of the proceeds if the government did not participate in the suit, or 15 to 25 percent if the government did participate in the suit.

Administrative Remedies for False Claims, 31 U.S.C. 3801-3812 – This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows is false, or contains false information, or omits material information, then the company receiving the claim may impose a penalty of up to \$5,000 for each claim. The company may also recover twice the amount of the claim.

Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid. Also, unlike the False Claims Act, the determination of whether a claim is false and the imposition of fines and penalties is made by the administrative company, not by prosecution in the federal court system.

Whistleblower protection—Humana Long-Term Care Plan staff, contracted providers, entities and agents are protected from retaliation from Medicaid services in the event that they report suspected filing of false or fraudulent claims against the government by Humana.

The federal False Claims Act (31 U.S.C. 3730(h)) provides for relief from retaliatory actions. Under the Act, “any employee, contractor or agent shall be entitled to relief necessary to make that employee, contractor or agent whole, if that employee, contractor or agent is discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent or associated others in furtherance of an action under this section or other efforts to stop one or more violations ...”

Similar protections exist under the Florida False Claims Act. (§68.088, F.S.), which states that “Any employee who is discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this act, including investigation for initiation of, testimony for or assistance in an action filed or to be filed under this act, shall have a cause of action ...”

FORMAL GRIEVANCES/APPEALS

A provider may file a grievance or an appeal for denial of payment/services, termination of payments/services or reduction of payments/services on behalf of a Humana Long-Term Care Plan member. Grievances are filed as complaints about services provided or about the appeal process itself. These may be filed by the member, member representative or a provider on behalf of a member. The formal grievance must be submitted orally or in writing either by letter or by completed grievance/appeal form to the Grievance and Appeal Department within 365 days from the date of the event that caused your concern or grievance.

Formal appeals are filed in response to Humana Long-Term Care Plan’s decision to:

- Deny payment
- Deny or limit the authorization of a requested service
- Reduce, suspend or terminate a previously authorized service

Formal appeals must be made within 30 days of written notice of Humana Long-Term Care Plan’s decision to reduce and/or deny service payments. Appeals may be made orally or in writing. Oral appeals must be followed up with a signed, written appeal, unless they are expedited.

Humana Long-Term Care Plan considers the member or member’s representative as parties to an appeal or a grievance. We encourage the member or member’s representative to explore the informal complaint process first in an attempt to work out the issue directly with the care manager and/or the

supervisor. If the concern or complaint was not resolved satisfactorily with the care manager, a grievance or appeal may be filed with Humana Long-Term Care Plan.

Please send formal appeals or grievances to the Grievance and Appeal at the following address:

Humana Long-Term Care Plan
Attn: Grievance/Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546

For questions, call 1-866-352-1192.

If the member or member's representative wishes to write a letter to the grievance/appeal department addressing the concern, the letter should include the member's name, address, member ID number, date and signature. The care manager is available to assist with this process, if needed.

Upon oral receipt of the grievance or completed grievance form, the grievance/appeal specialist will have the concern investigated and a written decision will be mailed to the member within 90 days.

Upon oral receipt of the appeal (followed by a signed written copy), the grievance/appeal coordinator will have the concern investigated and a written decision will be mailed to the member within 45 days. The individual(s) who originally made the decision to reduce or deny services will not be a decision-maker in the determination process.

To request a complete description of Humana Long-Term Care Plan's grievance/appeals procedure, please call our Provider Customer Service Department toll free at 1-888-998-7735.

Expedited appeals – If Humana Long-Term Care Plan deems the request urgent, an expedited review will take place. This process can only be utilized if a Humana Long-Term Care Plan member is being denied access to services. The individual(s) who originally made the decision to reduce or deny services will not be a decision-maker in the determination process.

Within three business days after receipt of the request, a decision will be determined and the member or representative will be notified by phone. The final determination will be sent to the member in writing.

At the conclusion of the appeal process, in the event of a ruling in favor of Humana Long-Term Care Plan, the member may have to pay for services rendered during the appeal process.

Subscriber Assistance Program – In the event the member or member’s representative has received a notice of resolution after a Humana Long-Term Care Plan internal appeal, the member or member’s representative may request review of that decision within one year by the Subscriber Assistance Program. The member or member’s representative may not request the review if there is already a requested Medicaid Fair Hearing. The program is operated by AHCA and may be contacted at:

Agency for Health Care Administration
Subscriber Assistance Program
Building 3, Mail Stop #45
2727 Mahan Drive
Tallahassee, FL 32308
Telephone: 1-850-412-4502
Toll-free telephone: 1-888-419-3456

Medicaid Fair Hearing – (a) An enrollee who chooses to exhaust the Managed Care Plan’s appeal process may still file for a Medicaid Fair Hearing within ninety (90) days of receipt of the Managed Care Plan’s notice of resolution. (b) An enrollee who chooses to seek a Medicaid Fair Hearing without pursuing the Managed Care Plan’s appeal process must do so within ninety (90) days from the date on the Managed Care Plan’s notice of action.

The member or member’s representative must contact:

Department of Children and Families
Office of Appeal Hearings
Building 5, Room 255
1317 Winewood Blvd.
Tallahassee, FL 32399-0700

Telephone: 1-850-488-1429
Fax: 1-850-487-0662
Email: Appeal_Hearings@dcf.state.fl.us

A member or provider may contact AHCA’s statewide consumer center at 1-888-419-3456.

IMPORTANT INFORMATION REGARDING BENEFITS DURING THE APPEAL AND/OR MEDICAID FAIR HEARING PROCESS

Continuation of benefits – Humana Long-Term Care Plan shall continue the enrollee’s benefits during the appeal and/or Medicaid Fair Hearing process if:

- The enrollee or the enrollee’s authorized representative files an appeal with Humana Long-Term Care Plan regarding Humana Long-Term Care Plan’s decision:
 - Within 10 days after the notice of the adverse action is mailed
 - Within 10 days after the intended effective date of the action, whichever is later

- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider
- The original period covered by the original authorization has not expired
- The enrollee requests extension of benefits
 - If, at the enrollee's request, Humana Long-Term Care Plan continues or reinstates the benefits while the appeal or fair hearing is pending, benefits must continue until one of the following occurs:
 - The enrollee withdraws the appeal;
 - Ten days pass after Humana Long-Term Care Plan sends the enrollee the notice of resolution of the appeal against the enrollee, unless the enrollee within those 10 days has requested a Medicaid Fair Hearing with continuation of benefits;
 - The Medicaid Fair Hearing office issues a hearing decision averse to the enrollee; or
 - The time period or service limits of a previously authorized service have been met.
 - If the final resolution of the appeal or fair hearing is adverse to the enrollee and Humana Long-Term Care Plan's action is upheld, Humana Long-Term Care Plan may recover the cost of services furnished to the enrollee while the appeal or fair hearing was pending to the extent they were furnished solely because of the continuation of benefits requirement.
 - If the Medicaid Fair Hearing officer reverses Humana Long-Term Care Plan's action and services were not furnished while the appeal was pending, Humana Long-Term Care Plan shall authorize or provide the disputed services promptly. If the Medicaid Fair Hearing officer reverses Humana Long-Term Care Plan's action and the enrollee received the disputed services while the appeal was pending, Humana Long-Term Care Plan shall pay for those services in accordance with its contract.

7 FORMS

Authorization form

Claim forms:

- CMS-1500
- UB-04

Provider Complaint Form

Provider Notice of Change Form (PNCF)

AUTHORIZATION FORM

The following form serves as a template for the following situations:

- New authorization
- Termination of services
- Suspension/Resumption of services
- Change of services



LTSS - Service Authorization

Created / Updated Date:				Created / Updated By:			
Member Information							
Member Name:				Address:			
City:				State:			
Zip:				Phone #:			
DOB:				Subscriber ID:			
Service							
Create Date:				Authorization Number:			
Provider Name:				Provider Phone:			
Provider Fax Number:				Care Manager:			
Care Manager Phone #:				Start Date:			
End Date:				Service Type:			
Service:				Procedure Code:			
Total Service Units:							
Total Units- Days of Week (Weekly)							
Days:							
Total Units							
Frequency:							
Days:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Units:							
Special Considerations:							

CLAIM FORMS

<div style="border: 1px solid black; display: inline-block; padding: 2px 5px;">1500</div> HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 0805</small>												<small>CARRIER</small> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div>
<small>1500 PICA</small> <div style="float: right; text-align: right;"> <small>PICA</small> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> </div>												
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> PECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>				1a. INSURED'S I.D. NUMBER <small>(not Program in Item 1)</small>								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE <small>MM DD YY</small>		SEX <small>M <input type="checkbox"/> F <input type="checkbox"/></small>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street) <small>CITY STATE ZIP CODE TELEPHONE (Include Area Code)</small>				6. PATIENT RELATIONSHIP TO INSURED <small>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></small>		7. INSURED'S ADDRESS (No., Street) <small>CITY STATE ZIP CODE TELEPHONE (Include Area Code)</small>						
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. D. PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR PECA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <small>YES <input type="checkbox"/> NO <input type="checkbox"/></small>		a. INSURED'S DATE OF BIRTH <small>MM DD YY</small>		SEX <small>M <input type="checkbox"/> F <input type="checkbox"/></small>				
b. OTHER INSURED'S DATE OF BIRTH <small>MM DD YY</small>				b. AUTO ACCIDENT? <small>YES <input type="checkbox"/> NO <input type="checkbox"/></small>		b. EMPLOYER'S NAME OR SCHOOL NAME						
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <small>YES <input type="checkbox"/> NO <input type="checkbox"/></small>		c. INSURANCE PLAN NAME OR PROGRAM NAME						
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <small>YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete Item 9 a-d.</small>						
<small>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</small>												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. <small>SIGNED _____ DATE _____</small>						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <small>SIGNED _____</small>						
14. DATE OF CURRENT <small>(ILNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP))</small> <small>MM DD YY</small>				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE <small>MM DD YY</small>				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION <small>FROM MM DD YY TO MM DD YY</small>				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____ 17b. NPI _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES <small>FROM MM DD YY TO MM DD YY</small>				
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? <small>YES <input type="checkbox"/> NO <input type="checkbox"/></small>				CHARGES				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Follow Item 1, 2, 3 or 4 to Item 24b by Line)				22. MEDICAID RESUBMISSION CODE				ORIGINAL REF. NO.				
1. _____				2. _____				23. PRIOR AUTHORIZATION NUMBER				
24. A. DATE(S) OF SERVICE <small>From MM DD YY To MM DD YY</small>				B. PLACE OF SERVICE <small>CMS</small>				C. PROCEDURE, SERVICE, OR SUPPLY <small>(Explain Unusual Circumstances)</small>				
D. DIAGNOSIS <small>ICD-9-CM</small>				E. CHARGES <small>ICD-9-CM</small>				F. ID. CHARGES <small>ICD-9-CM</small>				
1				2				3				
4				5				6				
7				8				9				
10				11				12				
13				14				15				
16				17				18				
19				20				21				
22				23				24				
25. FEDERAL TAX I.D. NUMBER <small>SSN</small> <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.				27. ACCOUNT ASSIGNMENT <small>YES <input type="checkbox"/> NO <input type="checkbox"/></small>				
28. TOTAL CHARGE \$				29. AMOUNT PAID \$				30. BALANCE DUE \$				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER <small>(I certify that the statements on this invoice apply to this bill and are made a part thereof.)</small>				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH#				
SIGNED _____ DATE _____				a. NPI				b. NPI				

NUCC Instruction Manual available at: www.nucc.org
APPROVED CMB-09-85-0000 FORM CMS-1500 (08-05)

UB-04

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**PROVIDER COMPLAINT FORM
PRIVILEGED AND CONFIDENTIAL**

PROVIDER INFORMATION	
Provider/Agency Name	
Address	City, State, Zip
Phone	Fax
Contact Person	Email

COMPLAINT DESCRIPTION
<i>Give a clear concise description of the complaint. (Attach extra sheet of paper if more space is needed.)</i>
SAMPLE

Signature

Date

For internal use only: _____
Humana Representative

Date Received

Mail to: Humana
Attn: Provider Contracting Department
14565 Sims Road, Delray Beach, FL 33436

Contact: Fax: 1-561-860-8660
For questions, call: 1-888-998-7735

PROVIDER NOTICE OF CHANGE FORM (PNCF)



INSTRUCTIONS: Please complete STEPS 1 through 5 below (as applicable). Authorization required to process.

STEP 1: PNCf Submitted By:		STEP 2: TYPE OF CHANGE (check applicable box):							
Contact Name: Susanne Roberts Company/Facility Name: Baker County Medical Services INC/ W Frank Wells Nursing Home (LEGAL AND DBA)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Add Location</td> <td style="width: 50%;"><input type="checkbox"/> Physical Address Change</td> </tr> <tr> <td><input type="checkbox"/> AUTHORIZATION Fax Change</td> <td><input type="checkbox"/> Staffing/Personnel Change</td> </tr> <tr> <td><input checked="" type="checkbox"/> Billing Address Change (W-9 Required)</td> <td><input type="checkbox"/> Tax ID/EIN Number Change (W-9 Required)</td> </tr> <tr> <td><input type="checkbox"/> Facility Phone Number Change</td> <td><input type="checkbox"/> Terminate Location</td> </tr> </table>	<input type="checkbox"/> Add Location	<input type="checkbox"/> Physical Address Change	<input type="checkbox"/> AUTHORIZATION Fax Change	<input type="checkbox"/> Staffing/Personnel Change	<input checked="" type="checkbox"/> Billing Address Change (W-9 Required)	<input type="checkbox"/> Tax ID/EIN Number Change (W-9 Required)	<input type="checkbox"/> Facility Phone Number Change	<input type="checkbox"/> Terminate Location
<input type="checkbox"/> Add Location	<input type="checkbox"/> Physical Address Change								
<input type="checkbox"/> AUTHORIZATION Fax Change	<input type="checkbox"/> Staffing/Personnel Change								
<input checked="" type="checkbox"/> Billing Address Change (W-9 Required)	<input type="checkbox"/> Tax ID/EIN Number Change (W-9 Required)								
<input type="checkbox"/> Facility Phone Number Change	<input type="checkbox"/> Terminate Location								
STEP 3: WRITE IN CHANGES in SECTIONS BELOW (as applicable)									
A) ADDRESS CHANGE: Note: Separate forms if adding/deleting more than one location Effective Date of Change: _____ Old Address: _____		B) ADD or TERMINATE LOCATION: Note: Separate forms if adding/deleting more than one location Counties Served: _____ Phone: () _____ AUTHORIZATION Fax: () _____							
C) CHANGE FACILITY PHONE or FAX# ONLY: Current #: () _____ New #: () _____ If Multiple Locations – indicate location for this change: _____		D) TAX ID/EIN # CHANGE PREVIOUS TAX ID: _____ NEW TAX ID: _____ Is this a Social Security Number: <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date of Change: _____							
E) STAFFING/PERSONNEL CHANGE									
TITLE & NAME:		PHONE NUMBER:							
STEP 4: ADDITIONAL COMMENTS:									
Physical Address - 210 North Second Street Macclenny FL 32063 Billing address - 159 NORTH THIRD STREET MACCLENNY, FL 32063 - FEI/EIN Number 59-3202547									
STEP 5: AUTHORIZATION - Changes will not be processed unless signed			HAEC INTERNAL USE						
I certify that the information provided herein is complete and accurate, and I agree, if a new location is added, that the services the provider renders to American Eldercare, Inc. members will be provided according to the terms and conditions of the service agreement between my company and American Eldercare, Inc.:			DATE REC'D:						
Authorized Signature:		DATE:	PROCESSED BY:						
Printed Name:		Print Title:	PRIDE ID:						

PLEASE SEND COMPLETED FORM TO: Humana, Provider Relations Department
 14565 Sims Road, Delray Beach, FL 33484 • Corporate **FAX: 561-865-2006**

APPENDIX

- [Contact us](#)
- [CARES offices](#)
- [Claim denial codes](#)
- [Remittance advice](#)

CONTACT US

Visit our website: [Humana.com/Humanalongtermcare](https://www.humana.com/Humanalongtermcare)

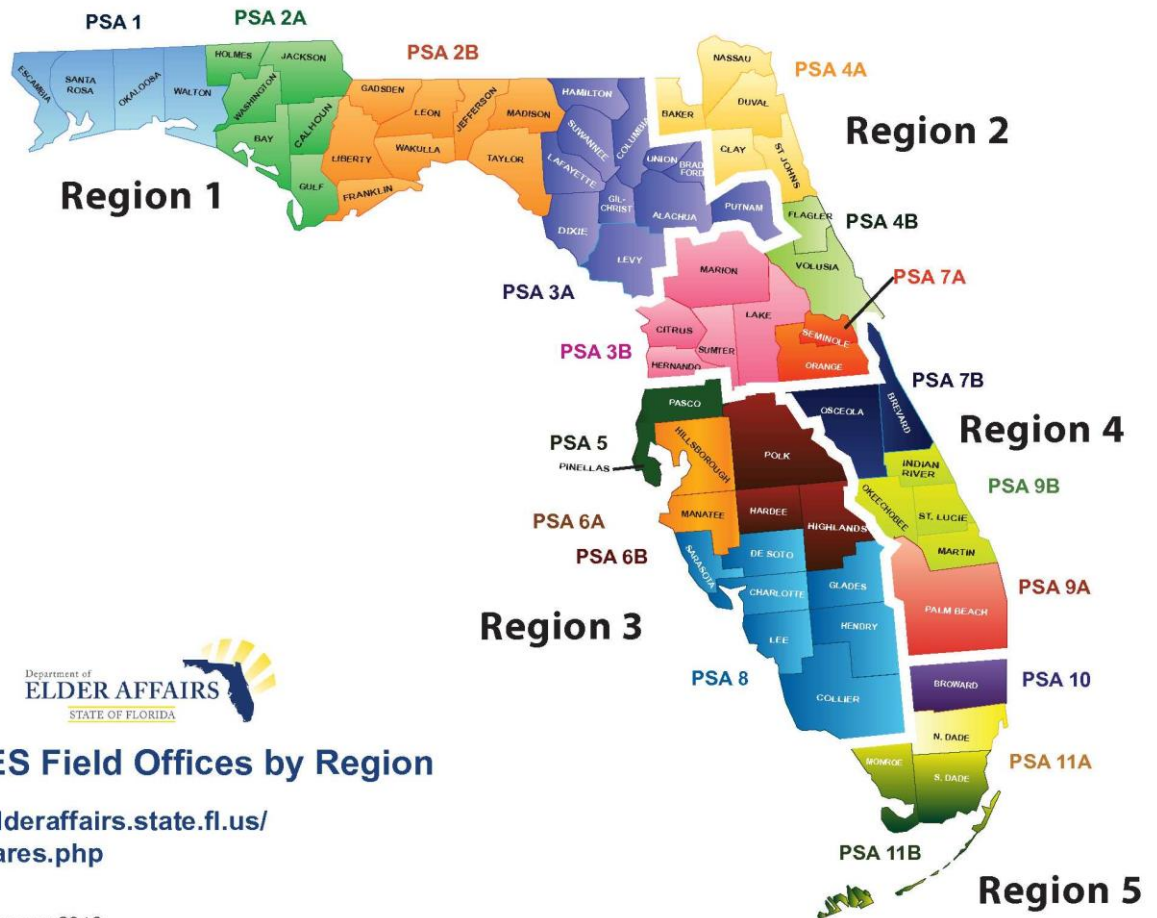
- Provider Help Line: 1-888-998-7735
Available Monday through Friday, 8 a.m. to 8 p.m.
- Member Help Line: 1-888-998-7732
Available 24 hours a day, 7 days a week.
- Corporate office:
Humana Long-Term Care Plan
14565 Sims Road
Delray Beach, FL 33484

CARES OFFICES

Department of Elder Affairs
Comprehensive Assessment and Review for Long-Term Care Services (CARES)

Area served	Phone number	PSA Office
Escambia, Okaloosa, Walton and Santa Rosa counties	1-850-916-6700	1
Bay, Calhoun, Gulf, Jackson, Washington and Holmes counties	1-850-747-5840	2A
Leon, Franklin, Gadsden, Madison, Taylor, Wakulla, Liberty and Jefferson counties	1-850-414-9803	2B
Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee and Union counties	1-352-955-6560	3A
Citrus, Hernando, Lake, Marion and Sumter counties	1-352-620-3457	3B
Baker, Clay, Duval Nassau and St. Johns counties	1-904-391-3920	4A
Flagler and Volusia counties	1-386-238-4946	4B
Pasco and Pinellas counties	1-727-588-6882	5
Hillsborough and Manatee counties	1-813-631-5300	6A
Polk, Hardee and Highlands counties	1-863-680-5584	6B
Orange and Seminole counties	1-407-540-3865	7A
Brevard and Osceola counties	1-321-690-6445	7B
Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota counties	1-239-338-2571	8
Palm Beach County	1-561-840-3150	9A
Indian River, Martin, Okeechobee and St. Lucie counties	1-772-460-3692	9B
Broward County	1-954-597-2240	10
Miami-Dade County (north and central)	1-786-336-1400	11A
Miami-Dade (south) and Monroe counties	1-305-671-7200	11B

CARES Field Offices by Region



CLAIM DENIAL CODES

CODE	DESCRIPTION
010	Services billed prior to services being rendered.
011	Diagnosis is inconsistent with the procedure.
012	Member was voluntarily disenrolled for the following service period.
013	Date of death precedes the date of service.
014	Total does not match the claim.
015	Denied: Noncontracted provider
016	Resubmit complete claim: EOB and claim.
016A	Claim lacks the anesthesia configuration in minutes, which is needed for processing.
016B	Resubmit complete claim: EOB does not match claim.
016C	Resubmit complete claim: EOB is unreadable.
016D	Resubmit complete claim: EOB is altered.
017	Service type not specified.
017A	Service type not authorized.
018	Duplicate claim or service/claim is in process.
019	Date of service does not match authorization.
020	Absence of authorization for billed month.
021	Item not authorized.
021-A	Denied: Item authorized only once a month.
022	Claim is unreadable; please resubmit complete claim.
023	Resubmit complete claim: EOB is unreadable, altered or does not match claim.
028	Coverage not in effect at the time the service was provided.
029	The time limit for filing has expired.
030	Not covered by this provider, bill Medicaid for this service.
031	Claim denied as patient cannot be identified as our insured.
032	Service not authorized.
033	Services suspended for billed dates.
034	Rate billed is inconsistent with contracted rate.
034A	Humana contribution: See comments.
035	Days billed are inconsistent with authorized days.
036	Payment for this claim must be adjudicated by primary insurance first.
037	Service not rendered on this date/notes do not match claim.
038-1	Denied: One day a week authorized.
038-2	Denied: Two days a week authorized.
038-3	Denied: Three days a week authorized.
038-4	Denied: Four days a week authorized.
038-5	Denied: Five days a week authorized.
038-6	Denied: Six days a week authorized.
038-7	Denied: Seven days a week authorized.
039-2	Denied: Service authorized every two months.
039-3	Denied: Service authorized every three months.

CODE	DESCRIPTION
042	Charges exceed Medicaid maximum allowable amount.
042A	There is no coverage on coinsurance for inpatient hospital stays.
048	This procedure is not covered.
048A	This copayment is not covered.
048B	Effective 7/1/08, HMO copayments are no longer covered. New coverage as per Medicaid guidelines.
049	Due to Medicare/Medicaid crossover rules, it has been determined that this procedure is denied in conjunction with Medicare's determination.
050	This is a noncovered service because the primary payer does not deem this a medical necessity.
062	Payment denied for absence of authorization.
096	Noncovered charge(s).
097	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
100	Claim denied at this time due to inactive or lack of active W-9 status.
101	Claim denied due to incorrect federal tax Identification or employer identification number.
109	Services not covered because the member/patient was placed in a hospice-contracted bed at the facility.
110	Billing date precedes service date.
135	Claim denied: Interim bills cannot be processed.
148	Claim or service rejected at this time because information from another provider was not provided or was insufficient or incomplete.
149	Requesting proof of patient responsibility payment.
150	Payment adjusted because the payer deems the information submitted does not support this level of service.
151	Claim denied for alteration with white-out.
170	Payment is denied when performed by this type of provider.
171	Denied: (Senate Bill 2800) Effective July 1, 2007, Medicaid will pay no portion of Medicare coinsurance for this type of service.
172	Processed per Medicaid guidelines. Zero payment due.
300	Claim payment issued to another provider due to change of ownership notification.
301	Payment not rendered at this time. Documentation submitted was insufficient. The Humana only reimburses payment with the Humana reimbursement form, the original receipt and prescription description.
302	Physician copayments and prescription copayment reimbursement benefit was not effective until Jan. 1, 2009.
303	Payment not rendered. The Humana Long-Term Care Plan only reimburses copayments for medications that are covered by the member's Medicare Part D provider. Please contact the member's care manager for details.

CODE	DESCRIPTION
304	Payment not rendered. This item is not an over-the-counter prescription purchase. Mail-order prescription refills and supplies are not reimbursable with this Humana prescription drug plan.
305	Receipts must be submitted within 30 days of purchase in order to be reimbursed by Humana's prescription drug plan.
306	Humana only reimburses inpatient and physician copayments. Humana does not render payment for coinsurance or deductible amounts.
307	Humana only reimburses for prescription copayments for Medicare D plans that serve the dually enrolled.
308	Member copayment not reimbursable at this time. Please submit updated insurance information to the assigned care manager. Humana claims department will reprocess claims within 30 days after requested information has been received.
309	Copayment reimbursement not rendered at this time. Please submit official physician receipt or itemized statement as proof of payment. Handwritten receipts are not acceptable.
310	Please rebill Humana as a secondary insurance carrier with the primary insurance carrier's EOB attached. This is not a copayment-reimbursable item.
311	Member copayment not reimbursable at this time. Please contact the assigned Humana care manager.
312	The receipts submitted equal payment reimbursed, but not the reimbursement requested amount.
A01	Service type not specified.
A02	Duplicate claim already in process.
A03	Duplicate claim: Payment already issued.
A04	Resubmit complete claim and EOB: Claim and/or EOB unreadable, altered or does not match.
A05	Rate billed is inconsistent with contracted rate.
A06	Patient allowance changed.
A07	Claim lacks the anesthesia configuration in minutes needed for processing.
A08	Payment for this claim must be adjudicated by primary insurance prior to submission.
A09	Payment issued to another provider due to change of ownership notification.
A10	Incorrect federal tax identification.
A11	Lack of correct W-9 on file for provider.
A12	Incomplete provider file.
A13	PASRR not performed in a complete, timely and accurate manner.
A14	PASRR determined member inappropriate for nursing facility.
A15	Incorrect type of bill.
A16	Resubmit with correct revenue code.
A17	No member liability submitted on claim.
A18	Provider not on file.
A19	Service dates cannot contain more than one month.
A20	Date ranges are not allowed.

CODE	DESCRIPTION
A21	Date of service missing/incomplete.
A22	Incorrect procedure code.
A23	No tax ID.
A24	No billing address.
A25	Place of service denial.
A26	NPI/Medicaid/taxonomy denial.
A27	Denied for missing or invalid claim data.
A28	Denied for EOB not attached or missing.
A29	Date of service does not match number of units.
A30	Missing/invalid discharge status code.
AEC00	Recommendation: Insufficient information to process, please update.
AEC1	Recommendation: Vendor not found.
AEC10	Recommendation: Duplicate. Previously denied. Please review.
AEC11	Recommendation: Possible duplicate claim previously paid. Please review.
AEC12	Recommendation: No authorization found. Possible denial. Please review.
AEC2	Recommendation: CPT code not found.
AEC3	Recommendation: Type of bill not found.
AEC4	Recommendation: Date range problem/eligibility issue. Please adjudicate manually.
AEC5	Recommendation: No diagnosis listed or not found.
AEC6	Recommendation: Statement from/through are blank or invalid.
AEC7	Recommendation: Pay/deny does not match system calculations.
AEC8	Recommendation: Possible duplicate claim. Please review.
AEC9	Recommendation: Statement dates match a previously processed claim. Please review.
AEC99	Recommendation: Zero units/days billed. Please review.
B01	Service not covered.
B02	Copayment not covered.
B03	Coverage not in effect at the time the service was provided.
B04	Claim denied as patient cannot be identified as our insured.
B05	Exceeds Medicare/Medicaid maximum allowable or plan maximum allowable.
B06	Service not covered due to determination by primary insurance.
B07	This provider was not certified or eligible to be paid for this procedure or service on this date of service.
B07	Not covered under Medicaid Waiver, covered under Medicaid Fee-for-Service.
B08	Denied: Effective July 1, 2007 (Senate Bill 2800), exceeds Medicaid maximum allowable.
B09	Please rebill Diversion and LTCMC charges separately.
B13	Previously paid: Payment for this claim or service has been provided in a previous payment.
B14	Service was processed on a previous claim/date.
C01	Service not authorized.
C02	Service not authorized for this date(s).

CODE	DESCRIPTION
C03	Exceeds authorized number of days or hours per week.
C04	Service authorized for once a month.
C05	Service authorized for once every two months.
C06	Service authorized for once every three months.
D01	Services billed prior to date of service.
D02	Service not rendered on the date(s) specified.
D03	Time limit for filing has expired.
D04	Date of death precedes date of service.
E01	Mail-order prescription refills and supplies are not reimbursed.
E02	Reimbursement is made for copayments on medications that are covered by your Medicare Part D provider.
E03	You are not enrolled with a Medicare Part D provider for which copayments are reimbursed.
E04	Receipts not submitted within 30 days of purchase.
E05	Receipts submitted do not match claim total.
E06	Resubmit claim including the Humana Long-Term Care Plan reimbursement form, original receipt(s) and pharmacy label.
ERROR	ERROR: Conflicting payment rules, please notify IT department.
PR1	Please contact your local provider contracting specialist.
SC14	Special circumstances.
SNFEOP	SNF day rate paid.
Z01	Provider improperly refuses access to members.

SECTION III – HUMANA COMPREHENSIVE PLAN

INTRODUCTION

If you have a patient/member who is enrolled in both Humana’s MMA plan and LTC plan, the plan name will be **Humana Comprehensive**.

Please refer to Section I – Humana Medical Plan for providers who are rendering medical services.

Please refer to Section II – Humana Long-Term Care for providers who are rendering long-term-care services.

HUMANA COMPREHENSIVE PLAN ID SAMPLES

Humana.
Humana Comprehensive Plan

MEMBER NAME
Member ID: HXXXXXXXXX

Medicaid ID#: XXXXXX XX Group #: XXXXXXXX
 Date of Birth: XX/XX/XX RxBIN: 610649
 Effective Date: XX/XX/XX RxPCN: 03190000

PCP Name: XXXXXXXXXX
 PCP Phone: (XXX) XXX-XXXX
 Primary Care Address: XXXXXXXXXX

Member/Provider Service: 1-800-477-6931

Pharmacist Rx Inquiries: 1-800-865-8715
 Pre-Certification and/or admission notification call: 1-800-523-0023

Please mail all claims to:

Managed Medical Assistance	Long Term Care
Humana Medical	Humana Long Term Care
P.O. Box 14601	P.O. Box 14732
Lexington, KY 40512-4601	Lexington, KY 40512-4732

Spanish ID

Humana.
Humana Comprehensive Plan

MEMBER NAME
Id. del afiliado: HXXXXXXXXX

Id. de Medicaid: XXXX.XXXX N.º de grupo: XXXXXXXX
 Fecha de nacimiento: XX/XX/XX RxBIN: 610649
 Fecha de entrada en vigor: XX/XX/XX RxPCN: 03190000

Nombre del PCP: XXXXXXXXXX
 No. de teléfono del PCP: (XXX) XXX-XXXX
 Dirección de atención primaria: XXXXXXXXXX

Servicio para afiliados/proveedores: 1-800-477-6931

Consultas sobre recetas de farmacéuticos: 1-800-865-8715
 Precertificación y/o notificación de admisión llamar al: 1-800-523-0023

Por favor, envíe todas las reclamaciones por correo a:

Managed Medical Assistance	Long Term Care
Humana Medical	Humana Long Term Care
P.O. Box 14601	P.O. Box 14732
Lexington, KY 40512-4601	Lexington, KY 40512-4732