Illinois joint CMS-State sponsored Medicare Medicaid Alignment Initiative ("Demonstration") and Illinois Integrated Care Program (ICP) Appendix

WELCOME

Thank you for your participation with Humana, where our goal is to provide quality services to Demonstration and ICP Members.

This Provider Manual Appendix highlights the key points related to Humana Demonstration and ICP policies and procedures and is an extension of your contract. It is intended to be a guideline to facilitate and inform you and your staff on what the Illinois Demonstration and ICP program is about, what we need from you, and what you can expect from Humana, ILS and Beacon. The guidelines outlined in this Provider Manual Appendix are designed to assist you in providing caring, responsive service to our Humana Gold Plus® Integrated members.

We look forward to a long and productive relationship with you and your staff. Should you need further assistance, please contact your Network Management Consultant.

Sincerely,

Paul Maxwell

Vice President, Provider Development

Table of Contents

SECTION I – GENERAL PROVIDER INFORMATION

1. Program Description 5
1.1 Definitions 5

2. Covered Services 10
2.1 General Services 10
2.2 Out-of-Network Care for Services Not Available 10
2.3 Expanded Services 10
2.4 Benefit Summaries 10

3. Emergency Service Responsibilities 55
3.1 Emergency Mental Health Services 55

4. Model of Care and Care Coordination 56

5. Provider Complaints 60

6. Grievance and Appeals System 60

7. Chronic and Complex Conditions 62
7.1 Comprehensive Diabetes Care 62
7.2 Nephropathy 62
7.3 Congestive Heart Failure 62
7.4 Asthma 63
7.5 Hypertension 63
7.6 HIV/Aids 63
7.7 HEDIS Care of Older Adult (COA) Measures 63

8. PCP And Other Provider/Subcontractor Responsibilities 63
8.1 Access to Care 63
8.2 Patient–Centered Medical Home 64
8.3 ADA Compliance 65
8.4 Member Special Needs Consideration 65
8.5 Family Planning Service 66
8.6 Immunizations 67
8.7 Adult Health Screening 67
8.8 Hysterectomies, Sterilization and Abortions 69
8.9 Pregnancy Related Requirements 69
8.10 Domestic Violence, Alcohol and Substance Use, and Smoking Cessation 71
8.11 Quality Improvement Requirements 72
8.12 Community Outreach Provider Compliance 72
8.13 Illinois Medicaid Provider Number 72
8.14 Provider Education of Compliance-based Materials 73
8.15 Requirements regarding community outreach activities and marketing prohibitions 73
8.16 Hospice Care 74

9. Medical Records Standards 74

10. Claims Submission Protocols and Standards 75
10.1. Timely Filing 75

11. Cultural Competency 76

12. Member Rights and Responsibilities 78
12.1 Member Rights 78
12.2 Member Responsibilities 79

13. Fraud Waste and Abuse 80

14. Health Safety and Welfare 80

SECTION II – LONG-TERM CARE SERVICES

1. Introduction 81
1.1 Welcome 82
1.2 Overview 82

2. Provider Definition and Status 83
2.1 Provider Contracting, Application and Credentialing 84
2.2 Time Periods to Note 84

3. Provider Policies and Responsibilities 84
3.1 Equal Provider Opportunity 84
3.2 Affirmative Action, Diversity and the Cultural Competency Plan 85
3.3 Americans with Disabilities Act 85
3.4 Contract, Law and License Compliance 85
3.5 Provider Background Check 85
3.5.1 Criminal Record Check and Criminal Allegations 85
3.6 HIPAA Standards 85
3.7 Change of Provider Data 86
3.8 Provider Education and Compliance-based Materials 86
3.9 Emergency Service Responsibilities 86
3.9.1 Weather-related and Emergency-related Closings 86

4. Quality Improvement 87
4.1 Quality Improvement Program Overview 87
4.2 Provider Participation in the Quality Improvement Program 87
4.3 The ILS Focus™ Process 87

5. Standards of Conduct 88
5.1 Stakeholder Expectations 88
5.2 Reporting Significant Member Health Outcomes 89
5.3 Incident Reporting 89
5.4 Member Transition to Another Network Provider 89

6. Medicare-Medicaid Alignment Initiative Demonstration 90
6.1 Covered Services 90
6.2 Medical Necessity Standards and Practice Protocols 90
6.3 Health Plan Implements MMAI Demonstration Enrollment and Care Plans 91

7. Claims Submission Protocols and Standards 92
7.1 Provider Billing for Services 92
7.2 Instructions and All Information Required for a Clean or Complete Claim 92
7.3 Provider Billing 92
7.4 Examples of Acceptable Paper Claims Forms 92

7.5 Claims Submission 92
7.6 Clean Claim Submission 93
7.7 Claims Payment Time Frames 93
7.8 Claims Resubmission 93
7.9 Claims Reconsideration 94
7.10 Claims Inquiries 95
7.11 Provider Claims Disputes 95
7.12 Prior Authorization and Referral Procedures 95
7.13 Protocols for Submitting Encounter Data 95
7.14 Medical/Case Records Standards 96

8. Complaints 96

9. Tools and Information of Value 96
9.1 NPI – National Provider Identifier Standard 96
9.2 Credentialing 97
9.3 Attestations Adopted by and Applicable to Providers 97
9.4 Home and Community--based Services in Supportive Living Facilities 97

SECTION III – BEHAVIORAL HEALTH

1. Program Description 98
1.1 Beacon/Humana Partnership 98
1.2 Beacon/Humana Behavioral Health Program 99
1.3 Network Operations 99
1.4 Contracting and Maintaining Network Participation 99
1.5 About This Provider Manual Appendix 99
1.6 Transactions and Communications with Beacon 100
1.7 Access Standards 102
1.8 Provider Credentialing & Recredentialing 104
1.9 Prohibition on Billing Members 104

2. Members, Benefits and Member-related Policies 106
2.1 Covered Services 106
2.2 Member Rights and Responsibilities 106

3. Quality Management and Improvement 111
3.1 QM & I Program Overview 111
3.2 Treatment Records 112

4. Care Management 122
4.1 Care Coordination 122
4.2 Utilization Management 125
4.3 Level of Care Criteria (LOCC) 126
4.4 Utilization Management Terms and Definitions 126
4.5 Emergency Services 128
4.6 Authorization Requirements 129

5. Provider Appeals 133

6. General Claim Policies 134

7. Education and Outreach 137

8. Provider Education of Compliance-based Materials 144

ATTACHMENT A: AUTHORIZATION GUIDELINES 144

SECTION I – GENERAL PROVIDER INFORMATION

1. Program Description

The Medicare-Medicaid Alignment Initiative (Demonstration) for Dual Eligible Recipient and the Illinois Integrated Care Program (ICP) provides healthcare coverage for income-eligible children, seniors, disabled adults and pregnant women. The Illinois Department of Healthcare and Family Services ("Agency") is responsible for administering the state of Illinois (State) Demonstration and ICP programs and will administer contracts, monitor Health Plan performance, and provide oversight over all aspects of Health Plan operations. The State will contract with an enrollment broker/facilitator for assistance in administering the Demonstration and meeting Member (hereinafter "Member") needs. Providers should be familiar with and utilize the numerous resources available to Members, including the enrollment broker/facilitator. The enrollment broker/facilitator will be contracted with the State to facilitate education, enrollment, and outreach endeavors, and serve as a key customer service component for Demonstration Members.

The Demonstration and ICP programs are expected to transform the Dual-Eligible Demonstration and ICP programs by empowering Dual Eligible and Medicaid-only eligible recipients to take control of their healthcare, improve quality and health outcomes, streamline Medicare and Medicaid requirements, provide person-centered care focused on needs and preferences, reduce health disparities, and by enhancing Members' health status through increased health literacy and incentives to engage in healthy behaviors. Another goal of the program is to institute managed care principles to Demonstration Members.

By entering into a contract with the Agency to provide services to Demonstration and/or ICP Members, Humana has agreed to comply with the provisions of the Demonstration and ICP Contract(s) ("MMAI Contract" and/or ICP Contract) as well as with all applicable Agency rules relating to both the MMAI Contract and ICP Contract that may be implemented by the State to regulate the administration of the Demonstration and ICP.

Note: Section I of this Appendix applies to all Demonstration Providers. For additional detail related to Long Term Service and Support Providers, please see Section II of the Appendix; for additional detail related to Behavioral Health Providers, please see Section III of this Appendix.

1.1 Definitions

The following are definitions that are specific to this Appendix:

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

Agency – Illinois Department of Healthcare and Family Services

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

Benefits – A schedule of healthcare services to be delivered to Member covered by the Health Plan as set forth in Section Two (2) of this Appendix

Children/Adolescents – Members under the age of 21

Complaint – Any oral or written expression of dissatisfaction by a Member 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 Member'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.

Contract(s) – The Contract between U.S. DHHS Centers for Medicare & Medicaid Services in Partnership with State of Illinois DHFS and Humana for the Medicare-Medicaid Alignment Initiative (MMAI) Demonstration (MMAI Contract) and/or the State of Illinois Contract between the Department of Healthcare and Family Services and Humana Health Plan, Inc. for furnishing health services in an Integrated Care Program (ICP) by a managed care organization (ICP Contract).

County Health Departments (CHD) – CHDs are organizations administered by the Department of Health for the purpose of providing health services, which include the promotion of the public's health, the control and eradication of preventable diseases, and the provision of primary healthcare for special populations.

Covered Service – A service provided by the Health Plan in accordance with the Health Plan's Demonstration and ICP Contract, and as outlined in Section II (2) Covered Services of this Appendix.

Dual Eligible Recipient – Any individual whom the State, or the Social Security Administration on behalf of the State, 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 Demonstration program, and who is enrolled in the Demonstration program.

Consumer-directed (CD) Model of Services – The model of service delivery for which the waiver Member or the Member's employer of record, as appropriate, are responsible for hiring, training, supervising, and firing of the person or persons who actually render the services that are reimbursed by the State.

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:

(1) Serious jeopardy to the health of a patient, including a pregnant woman or fetus;

(2) Serious impairment to bodily functions;

(3) Serious dysfunction of any bodily organ or part.

(4) With respect to a pregnant woman:

  (a) That there is inadequate time to affect safe transfer to another hospital prior to delivery;

  (b) That a transfer may pose a threat to the health and safety of the patient or fetus;

  (c) That there is evidence of the onset and persistence of uterine contractions or rupture of other membranes.

Emergency Services and Care – Medical screening, examination and evaluation by a 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.

Expanded Services – A Health Plan-covered Service for which the Health Plan receives no direct payment from the Agency.

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 Demonstration and ICP recipients by a Health Plan.

External Quality Review Organization – An organization that meets the competence and independence requirements set forth in Federal regulation 42 CFR 438.354, and performs EQR, other related activities as set forth in Federal regulations or both.

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 Member's rights.

HCBS Waiver – The CMS-approved §1915(c) waiver that covers a range of community support services offered to Members who are elderly or who have a disability who would otherwise require a nursing facility (NF) level of care.

Health Plan – An entity that integrates financing and management with the delivery of healthcare services to an enrolled population. It employs or contracts with an organized system of Providers, which delivers services. For the purposes of this Contract, a Health Plan has also contracted with the Agency to provide Demonstration and ICP services, and includes health maintenance organizations authorized under the Illinois Health Maintenance Organization Act, 215 ILCS 125 et seq. of the Illinois Statutes, exclusive provider organizations as defined in 50 Ill. Adm. Code 2051.220 of the Illinois Administrative Code, and health insurers authorized under 215 ILCS 5/352 et seq. of the Illinois Statutes.

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.

Mandates – Applicable State and Federal laws, regulations and mandates in existence at all times hereunder, including, without limitation, applicable Medicaid laws, Medicare laws, rules, regulations and CMS requirements. The term shall also include applicable MMAI and/or ICP requirements, policies and State and Federal government sponsor orders, directives, mandates and requirements of any kind.

Medicaid – The medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., and regulations there under, as administered in the State of Illinois by the Agency.

Medicaid Dual-Eligible Reform – The reforms resulting from the February 22, 2013, approval the Agency received from the Federal Centers for Medicare & Medicaid Services (CMS) to jointly implement the MMAI.

Medical Record – Documents corresponding to medical or allied care, goods or services furnished in any place of business. The records may be on paper, magnetic material, film or other media. 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 medum.

Medically Necessary or Medical Necessity –

IL MMAI
Medically Necessary Services means services, supplies or medicines that are appropriate, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. §1395y, covered by the Department, and meet the standards of good medical practice in the medical community, as determined by the Provider in accordance with the Demonstration Plan's guidelines, policies and procedures based on applicable standards of care and, as approved by CMS or the Department if necessary, for the diagnosis and treatment of a covered illness or injury, for the prevention of future disease, to assist in the Enrollee's ability to attain, maintain or regain functional capacity, or to achieve age-appropriate growth. Notwithstanding this definition, Plans will provide coverage in accordance with the more favorable of the current Medicare and Department coverage rules, as outlined in Illinois and Federal rules and coverage guidelines.

IL ICP
Medically Necessary means a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with Contractor's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the Enrollee's ability to attain, maintain or regain functional capacity, or to achieve age-appropriate growth.

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

Member – A Demonstration and/or ICP recipient currently enrolled in the Health Plan.

Non-covered Service – A service that is not a covered service/benefit.

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

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 twenty-four (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.

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

Patient-centered Medical Home – The Patient-centered Medical Home is a healthcare setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Patient Pay – The amount of the LTSS Member's income which must be paid as his/her share of the Medicaid Long Term Service Support (LTSS) services cost.

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 Provider (PCP) – A Health plan staff or contracted physician practicing as a general or family practitioner, internist, pediatrician, or other specialty approved by the Agency, who furnishes primary care and patient management services to a Member. Pregnant Members with chronic health conditions, disabilities or special healthcare needs may request other specialty/Provider medical homes that furnish Primary Care and patient management services to be designated as their PCP. Homebound Members or Members with significant mobility limitations may request Primary Care services through home visits by nurse practitioners or physicians.

Preauthorization – The act of authorizing specific services before they are rendered.

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 meets all State and/or Federal requirements (as appropriate) to provide Covered Services to Demonstration Members and/or ICP Members.

Participating Provider (or Network Provider) – Means a healthcare Provider who is contracted under a currently valid provider agreement to participate in a Health Plan's Medicare Advantage and/or Medicaid networks serving Demonstration Members and/or ICP Members.

Provider Contract – An agreement between the Health Plan and a Provider as described above.

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

Quality Improvement (QI) – The process of monitoring and assuring that the delivery of healthcare 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 Members.

Quality Improvement Program (QIP) – The process of assuring the delivery of healthcare is appropriate, timely, accessible, available and Medically Necessary.

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

State – State of Illinois.

Subcontract – An agreement entered into by the Health Plan for provision of administrative services on its behalf.

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.

Transportation – An appropriate means of conveyance furnished to a Member to obtain Demonstration and ICP authorized/Covered Services.

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

Well Care Visit – A routine medical visit for one of the following: Child Health Check-Up (CHCUP) visit, family planning, routine follow-up to a previously treated condition or illness, adult physicals or any other routine visit for other than the treatment of an illness.

2. Covered Services

2.1 General Services

The Demonstration and/or ICP Health Plan, through its contracted Providers, is required to arrange for Medically Necessary services for each Member.

In providing Covered Services to Demonstration and ICP Members, the Provider is required to adhere to applicable provisions in the Illinois Demonstration and ICP coverage, as well all State and Federal laws pertaining to the provision of such services.

2.2 Out-of-Network Care for Services Not Available

Upon notification of authorization from referring Provider, 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 participating network Provider is not available.

2.3 Expanded Services

Expanded services are those services offered by Humana and approved in writing by the Agency. Such services are outlined in the benefit summaries (Section 2.4(a) and 2.4(b)) below. For additional information Providers can call the customer service number provided on the back of the Humana Member's ID card.

Note: Humana's Provider network will also arrange, as necessary, for specialty care, LTSS, and behavioral health.

2.4 Benefit Summaries

2.4(a) Medicare Medicaid Alignment Initiative including Humana Gold Plus® Integrated (Medicare-Medicaid Plans)

General services that our plan covers	What Members must pay
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner or clinical nurse specialist.	$0 copayment
Alcohol misuse screening and counseling The plan covers one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, the plan covers up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.	$0 copayment

General services that our plan covers	What Members must pay
Ambulance services Covered ambulance services include fixed-wing, rotary-wing and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan. In cases that are *not* emergencies, the plan *may* pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0 copayment per date of service *Prior authorization may be required
 **Annual wellness visit** If you have been in Medicare Part B for more than 12 months, you can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. The plan will cover this once every 12 months. **Note:** You cannot have your first annual checkup within 12 months of your "Welcome to Medicare" preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a "Welcome to Medicare" visit first.	$0 copayment
 **Bone mass measurement** The plan covers certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. The plan will cover the services once every 24 months, or more often if they are medically necessary. The plan will also pay for a doctor to look at and comment on the results.	$0 copayment
 **Breast cancer screening (mammograms)** The plan will cover the following services: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	$0 copayment

General services that our plan covers	What Members must pay
Cardiac (heart) rehabilitation services The plan covers cardiac rehabilitation services such as exercise, education and counseling. Members must meet certain conditions with a doctor's referral. The plan also covers *intensive* cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0 copayment *Prior authorization may be required
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) The plan covers one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may: • discuss aspirin use, • check your blood pressure, or • give you tips to make sure you are eating well	$0 copayment
Cardiovascular (heart) disease testing The plan covers blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. Additional testing may be covered if deemed medically necessary by your primary care provider.	$0 copayment
Cervical and vaginal cancer screening The plan covers the following services: • For all women: Pap tests and pelvic exams once every 12 months	$0 copayment
Chiropractic services The plan covers adjustments of the spine to correct alignment.	$0 copayment *Prior authorization may be required

General services that our plan covers	What Members must pay
Colorectal cancer screening The plan covers the following services: • Flexible sigmoidoscopy (or screening barium enema) every 48 months • Fecal occult blood test, every 12 months • Screening colonoscopy For people at high risk of colorectal cancer, the plan will cover one screening colonoscopy (or screening barium enema) every 24 months. For people not at high risk of colorectal cancer, the plan will cover one screening colonoscopy every 10 years (but not within 48 months of a screening sigmoidoscopy). Additional screenings may be covered if deemed medically necessary by your primary care provider.	$0 copayment
Counseling to stop smoking or tobacco use If you use tobacco but do not have signs or symptoms of tobacco-related disease: • The plan will cover two counseling quit attempts in a 12 month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: • The plan will cover two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and are pregnant: • The plan will cover three counseling quit attempts within a 12 month period. This service is free for you. Each counseling attempt includes up to four face-to-face visits. You are covered for an additional smoking cessation benefit. See smoking cessation (QuitNet) on page 37.	$0 copayment *Prior authorization may be required

General services that our plan covers	What Members must pay
Dental services The plan covers the following dental services:. • Limited and comprehensive exams. • Restorations • Dentures • Extractions • Sedation • Dental emergencies • Dental services necessary for the health of a pregnant woman prior to delivery of her baby You are covered for the following additional dental benefits: · oral exams (once every 6 months) · prophylaxis-cleaning (once every 6 months) · one additional bitewing X-ray for non-pregnant adults above age 20	$0 copayment *Prior authorization may be required
 **Depression screening** The plan will cover one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.	$0 copayment
 **Diabetes screening** The plan will cover this screening (includes fasting glucose tests) if you have any of the following risk factors: • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.	$0 copayment

General services that our plan covers	What Members must pay
Diabetic self-management training, services and supplies The plan will cover the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: – A blood glucose monitor – Blood glucose test strips – Lancet devices and lancets – Glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, the plan will cover the following: – One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, ***or*** – One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) The plan will also cover fitting the therapeutic custom-molded shoes or depth shoes. • The plan will cover training to help you manage your diabetes, in some cases. • Diabetic shoes and inserts • Diabetic monitoring supplies	$0 copayment *Prior authorization may be required

General services that our plan covers	What Members must pay
Emergency care *Emergency care* means services that are: • given by a provider trained to give emergency services, ***and*** • needed to treat a medical emergency. A *medical emergency* is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • placing the person's health in serious risk; ***or*** • serious harm to bodily functions; ***or*** • serious dysfunction of any bodily organ or part; ***or*** • in the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur: – There is not enough time to safely transfer the member to another hospital before delivery. – The transfer may pose a threat to the health or safety of the member or unborn child. You are covered for emergency care world-wide.	$0 copayment If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital in order for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay.
Enhanced Medical Nutrition Therapy Members with diabetes, renal disease or who have received a kidney transplant in the last three years will receive an additional **1** counseling session in addition to their Medicare-covered benefit per calendar year. All other members will receive **4** counseling sessions per calendar year. Counseling sessions are provided one-on-one by a registered dietician or other nutrition professional and are one hour in duration.	$0 copayment

General services that our plan covers	What Members must pay
Family planning services The law lets you choose any provider to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office. The plan will cover the following services: • Family planning exam and medical treatment • Family planning lab and diagnostic tests • Family planning methods (birth control pills, patch, ring, IUD, injections, implants) • Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • Counseling and diagnosis of infertility, and related services • Counseling and testing for sexually transmitted infections (STIs), AIDS and other HIV-related conditions • Treatment for sexually transmitted infections (STIs) • Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) • Genetic counseling • Folic acid supplements and prenatal vitamins ordered by prescription and dispensed by a pharmacy The plan will also cover some other family planning services. However, you must see a provider in the plan's network for the following services: • Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) • Treatment for AIDS and other HIV-related conditions • Genetic testing	$0 copayment

General services that our plan covers	What Members must pay
Health and wellness education programs Fitness Get fit with Humana Fitness from the SilverSneakers® Fitness Program. With this benefit, you are covered for everything included with a membership* at participating fitness centers across the country. Your benefit also includes: • SilverSneakers classes designed exclusively for older adults to improve your body's strength and flexibility • On-site advisers to act as your contact for information and personalized service • Social activities and health education events • Access to www.silversneakers.com, where you can create exercise and nutrition plans, track fitness progress, find health articles and recipes, and more. • SilverSneakers® Steps personalized home fitness programs * Any nonstandard fitness center services that usually have an extra fee are not included in your membership.	$0 copayment
Health and wellness education programs Humana Active Outlook® Humana Active Outlook (HAO) is a lifestyle enrichment program with features such as HAO Publications, HAO website, Classes, Individual Health Coaching and other health and wellness educational materials.	$0 copayment
Health and wellness education programs Well Dine Inpatient Meal Program After an inpatient stay in either the hospital or a nursing facility, you are eligible to receive 2 meals per day for 5 days, at no cost to you. Ten nutritious, pre-cooked frozen meals will be delivered to your home. Meal program limited to 4 times per calendar year. Please contact Well Dine at 1-866-96Meals (1-866-966-3257) for further details or to take advantage of this benefi after your discharge.	$0 copayment *Prior authorization may be required

General services that our plan covers	What Members must pay
Hearing services The plan covers hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist or other qualified provider. The plan also covers the following: • Basic and advanced hearing tests • Hearing aid counseling • Fitting/evaluation for a hearing aid • Hearing aids one per ear every three years • Hearing aid batteries and accessories • Hearing aid repair and replacement of parts	$0 copayment *Prior authorization may be required
 **HIV screening** The plan pays for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, ***or*** • are at increased risk for HIV infection. For women who are pregnant, the plan pays for up to three HIV screening tests during a pregnancy.	$0 copayment
Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. The plan will cover the following services, and maybe other services not listed here: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy and speech therapy • Medical and social services • Medical equipment and supplies	$0 copayment *Prior authorization is required

General services that our plan covers	What Members must pay
Hospice care You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. Your hospice doctor can be a network provider or an out-of-network provider. The plan will cover the following while you are receiving hospice services: • Drugs to treat symptoms and pain • Short-term respite care • Home care, including home health aide services • Occupational, physical and speech-language therapy services to control symptoms • Counseling services ***Hospice services and services covered by Medicare Part A or B are billed to Medicare.*** ***For services covered by Humana Gold Plus Integrated (Medicare-Medicaid Plan) but not covered by Medicare Part A or B:*** • Humana Gold Plus Integrated (Medicare-Medicaid Plan) will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay nothing for these services. ***For drugs that may be covered by Humana Gold Plus Integrated (Medicare-Medicaid Plan) Medicare Part D benefit:*** • Drugs are never covered by both hospice and our plan at the same time. **Note:** If you need non-hospice care, you should call your Care Coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. To talk with a Care Coordinator, call Customer Care at 1-800-787-3311 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. However, please note that our automated phone system may answer your call after hours, during weekends and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. The call is free. Visit **Humana.com** for 24-hour access to information such as claims history, eligibility and Humana's drug list. There you can also use the physician finder and get health news and information.	$0 copayment When you are in a hospice program certified by Medicare, your hospice services and your Medicare Part A and B services related to your terminal illness are paid for by Medicare. Humana Gold Plus Integrated (Medicare-Medicaid Plan) does not pay for your services.

General services that our plan covers	What Members must pay
Immunizations The plan will cover the following services: • Pneumonia vaccine • Flu shots, once a year, in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules The plan will cover other vaccines that meet the Medicare Part D coverage rules.	$0 copayment
Inpatient hospital care The plan will cover the following services, and maybe other services not listed here: • Semi-private room (or a private room if it is medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units, such as intensive care or coronary care units • Drugs and medications • Lab tests • X-rays and other radiology services • Needed surgical and medical supplies • Appliances, such as wheelchairs • Operating and recovery room services • Physical, occupational and speech therapy • Inpatient substance abuse services • Blood, including storage, blood components and administration thereof • Physician services	$0 copayment You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control. *Prior authorization and referral may be required

General services that our plan covers	What Members must pay
Inpatient hospital care (*continued*) • In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell and intestinal/multivisceral. If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or at a distant location outside the service area. If Humana Gold Plus Integrated (Medicare-Medicaid Plan) provides transplant services at a distant location outside the service area and you choose to get your transplant there, we will arrange or pay for reasonable lodging and travel costs for you and one other person. Travel reimbursement requires a minimum of 100 miles one way to transplant center and is limited to **$10,000** per transplant.	
Inpatient mental health care • The plan will cover medically necessary psychiatric inpatient care at approved institutions.	$0 copayment *Prior authorization and referral may be required

General services that our plan covers	What Members must pay
Inpatient services covered during a non-covered inpatient stay If your inpatient stay is not reasonable and needed, the plan will not cover it. However, in some cases the plan will cover services you get while you are in the hospital or a nursing facility. The plan will cover the following services, and maybe other services not listed here: • Doctor services • Diagnostic tests, such as lab tests • X-ray, radium and isotope therapy, including technician materials and services • Surgical dressings • Splints, casts and other devices used for fractures and dislocations • Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that: – replace all or part of an internal body organ (including contiguous tissue), or – replace all or part of the function of an inoperative or malfunctioning internal body organ. • Leg, arm, back and neck braces, trusses, and artificial legs, arms and eyes. This includes adjustments, repairs and replacements needed because of breakage, wear, loss or a change in the patient's condition • Physical therapy, speech therapy and occupational therapy	$0 copayment *Prior authorization and referral may be required

General services that our plan covers	What Members must pay
Kidney disease services and supplies The plan will cover the following services: • Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease and your doctor must refer you. The plan will cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area • Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply **Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see "Medicare Part B prescription drugs" in this chart.**	$0 copayment *Prior authorization may be required

General services that our plan covers	What Members must pay
Medical equipment and related supplies The following general types of services and items are covered: • Nondurable medical supplies, such as surgical dressings, bandages, disposable syringes, incontinence supplies, ostomy supplies and enteral nutrition therapy • Durable medical equipment, such as wheelchairs, crutches, walkers, hospital beds, IV infusion pumps and supplies, and humidifiers. • Prosthetic and orthotic devices, compression stockings, shoe orthotics, arch supports, foot inserts • Respiratory equipment and supplies, such as oxygen equipment, CPAP and BIPAP equipment • Repair of durable medical equipment, prosthetic devices and orthotic devices • Rental of medical equipment under circumstances where patient's needs are temporary To be eligible for reimbursement, some services may be subject to prior approval and/or medical criteria. We will pay for all medically necessary durable medical equipment that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.	$0 copayment *Prior authorization may be required

General services that our plan covers	What Members must pay
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when referred by your doctor. The plan will cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We cover two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's referral. A doctor must prescribe these services and renew the referral each year if your treatment is needed in the next calendar year.	$0 copayment
Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Humana Gold Plus Integrated (Medicare-Medicaid Plan) will cover the following drugs: • Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient or ambulatory surgery center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen® or Procrit®) • IV immune globulin for the home treatment of primary immune deficiency diseases • Chemotherapy drugs and administration	$0 copayment *Prior authorization may be required

General services that our plan covers	What Members must pay
Non-emergency transportation The plan will cover transportation for you to travel to or from your medical appointments if it is a covered service. Types of nonemergency transportation include: • Medicar • Service car • Taxicab Unlimited round trip(s) per year by taxi, bus/subway, van, medical transport for trips allowed to nursing homes, to the pharmacy right after doctor visits, and other medical providers and locations.	$0 copayment *Prior authorization and referral may be required
Nurse Advice Call Line (HumanaFirst®) If you have questions about symptoms you're experiencing but aren't sure if you need to see your doctor, Humana can help. Call HumanaFirst, our advice line for members, 24 hours a day, seven days a week at 1-855-235-8530 (TTY 711). It's staffed by nurses who can help address your immediate health concerns and answer questions about particular medical conditions.	$0 copayment

General services that our plan covers	What Members must pay
Nursing-facility care and skilled-nursing facility care The plan will cover skilled nursing facilities (SNF) and intermediate care facilities (ICF). The nursing facilities provide the following services: The plan will pay for the following services and maybe other services not listed here: • A semi-private room, or a private room if it is medically needed, maintenance and cleaning • Meals, including special meals, food substitutes and nutritional supplements • Nursing services and resident supervision/oversight • Physician services • Physical therapy, occupational therapy and speech therapy • Drugs, and other medications available through a pharmacy without a prescription, ordered by your doctor as part of your plan of care, including over-the-counter medications and their administration • Noncustom durable medical equipment (such as wheelchairs and walkers) • Medical and surgical supply items (such as bandages, oxygen administration supplies, oral care supplies and equipment, one tank of oxygen per resident per month) • Additional services provided by a nursing facility in compliance with State and Federal requirements You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • A nursing facility where your spouse lives at the time you leave the hospital	$0 copayment *Prior authorization and referral may be required When your income exceeds an allowable amount, you must contribute toward the cost of services. This is known as the patient pay amount and is required if you live in a nursing facility. However, you may not end up having to pay an amount each month. Patient pay responsibility does not apply to Medicare-covered days in a nursing facility.

General services that our plan covers	What Members must pay
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, the plan will cover counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0 copayment
Non-Medicaid over-the-counter drugs You are eligible for up to $30 monthly benefit to be used toward the purchase of over-the-counter (OTC) health and wellness products available through Humana Pharmacy®, our mail-order pharmacy. The order form can be obtained by calling Customer Care.	$0 copayment
Outpatient diagnostic tests and therapeutic services The plan will cover the following services, and maybe other services not listed here: • X-rays • Radiation (radium and isotope) therapy, including technician materials and supplies • Lab tests • Blood, blood components and administration thereof • Other outpatient diagnostic tests – Surgical supplies, such as dressings – Splints, casts, and other devices used to reduce fractures and dislocations – Sleep study in a home- or facility-based setting – Diagnostic mammography	$0 copayment *Prior authorization and referral may be required

General services that our plan covers	What Members must pay
Outpatient hospital services The plan pays for medically needed services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. The plan will cover the following services, and maybe other services not listed here: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Some screenings and preventive services • Some drugs that you can't give yourself • Nuclear medicine services • Radiation therapy	$0 copayment *Prior authorization and referral may be required

General services that our plan covers	What Members must pay
Outpatient mental health care The plan will cover mental health services provided by: • A state-licensed psychiatrist or doctor, • A clinical psychologist, • A clinical social worker, • A clinical nurse specialist, • A nurse practitioner, • A physician assistant, • Community Mental Health Centers (CMHCs), • Hospitals, • Encounter rate clinics such as Federally Qualified Health Centers (FQHCs), • DASA licensed substance abuse providers, ***or*** • Any other Medicare-qualified mental health care professional as allowed under applicable state laws. The plan will cover the following types of outpatient mental health services: • Clinic services provided under the direction of a physician • Rehabilitation services recommended by a physician or Licensed Practitioner of the Healing Arts, such as mental health assessment, treatment planning, crisis intervention, therapy and case management • Day treatment services • Outpatient hospital services, such as Clinic Option Type A and Type B services • Substance abuse treatment The specific services each provider type listed above can deliver and any utilization controls on such services shall be determined by the plan consistent with Federal and State laws and all applicable policies and/or agreements.	$0 copayment *Prior authorization and referral may be required
Outpatient rehabilitation services The plan will cover physical therapy, occupational therapy and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0 copayment *Prior authorization and referral may be required

General services that our plan covers	What Members must pay
Outpatient substance abuse services The plan covers the following services: • Outpatient services (group or individual) • Intensive outpatient services (group or individual) • Detoxification services • Residential services • Diagnostic Psychiatric Evaluation	$0 copayment *Prior authorization and referral may be required
Outpatient surgery The plan will cover outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.	$0 copayment *Prior authorization and referral may be required
Partial hospitalization services *Partial hospitalization* is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.	$0 copayment *Prior authorization and referral may be required
Physical exam (Routine) In addition to the "Welcome to Medicare" preventive visit, you are covered for the following exam once per year: • Comprehensive preventive medicine evaluation and management, including an age and gender appropriate history, examination, and counseling/ anticipatory guidance/risk factor reduction interventions	$0 copayment

General services that our plan covers	What Members must pay
Physician/provider services, including doctor's offi visits The plan will cover the following services: • Medically necessary health care or surgery services given in places such as: – Physician's office – Certified ambulatory surgical center – Hospital outpatient department • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams given by your primary care provider, if your doctor orders it to see whether you need treatment • Some telehealth services, including consultation, diagnosis and treatment by a physician or practitioner for patients in rural areas or other places approved by Medicare • Second opinion by another network provider before a medical procedure • Nonroutine dental care. Covered services are limited to: – Surgery of the jaw or related structures, – Setting fractures of the jaw or facial bones, – Pulling teeth before radiation treatments of neoplastic cancer, ***or*** – Services that would be covered when provided by a physician	$0 copayment *Prior authorization and referral may be required

General services that our plan covers	What Members must pay
Podiatry services The plan will cover the following services: • Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • Routine foot care for members with conditions affecting the legs, such as diabetes You are also covered for additional podiatry benefits. You may self-refer for 6 visits per year to a network specialist for the services below • Treatment of flat feet or other structural misalignments of the feet • Removal of corns • Removal of warts • Removal of calluses • Hygienic care	$0 copayment *Prior authorization may be required
Prostate cancer screening exams The plan will cover a digital rectal exam and a prostate specific antigen (PSA) test once every 12 months for: • Men age 50 and older • African-American men age 40 and older • Men age 40 and older with a family history of prostate cancer	$0 copayment

General services that our plan covers	What Members must pay
Prosthetic devices and related supplies *Prosthetic devices* replace all or part of a body part or function. The plan will cover the following prosthetic devices, and maybe other devices not listed here: • Colostomy bags and supplies related to colostomy care • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) The plan will also cover some supplies related to prosthetic devices. It will also pay to repair or replace prosthetic devices. The plan offers some coverage after cataract removal or cataract surgery. See "Vision Care" on Page 38 for details.	$0 copayment *Prior authorization and referral may be required
Pulmonary rehabilitation services The plan will cover pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The member must have referral for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0 copayment *Prior authorization and referral may be required
Sexually transmitted infections (STIs) screening and counseling The plan will cover screenings for chlamydia, gonorrhea, syphilis and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. The plan will also cover up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. The plan will cover these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0 copayment

General services that our plan covers	What Members must pay
Smoking cessation (QuitNet) Stop smoking with QuitNet Comprehensive. Services include: • Web-based or telephonic coaching • The QuitNet, QuitGuide, and QuitTips email support • Over-the-counter nicotine replacement therapy, including patches, gums and lozenges **You can enroll by phone at 1-888-572-4074 or online at www.quitnet.com/humana**	$0 copayment
Urgently needed care *Urgently needed care* is care given to treat: • a nonemergency, ***or*** • a sudden medical illness, ***or*** • an injury, ***or*** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider. You are covered for urgently needed care in the United States and its territories.	$0 copayment

General services that our plan covers	What Members must pay
Vision care The plan covers the following: • Annual routine eye exams which includes refraction, up to one per year • Eye glasses (lenses and frames) limited to one pair in a 24-month period • Contact lenses limited to one pair in a 24-month period • Custom-made artificial eye • Low vision devices • Medically necessary contact lenses or glasses To be eligible for reimbursement, some services may be subject to prior approval and/or medical criteria. The plan covers outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. This includes treatment for age-related macular degeneration. For people at high risk of glaucoma, the plan covers one glaucoma screening each year. People at high risk of glaucoma include: • People with a family history of glaucoma, • People with diabetes, and • African-Americans who are age 50 and older. The plan covers one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.)	$0 copayment
 **"Welcome to Medicare" preventive visit** The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes: • A review of your health • Education and counseling about the preventive services you need (including screenings and shots) • Referrals for other care if you need it. **Important:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0 copayment

Benefits *not* covered by Humana Gold Plus Integrated (Medicare-Medicaid Plan), Medicare, or Medicaid

This section tells you what kinds of benefits are excluded by the plan. Excluded means that the plan does not cover these benefits. Medicare and Medicaid will not pay for them either.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not cover the excluded medical benefits listed in this section (or anywhere else in this Provider Handbook) except under the specific conditions listed. If you think that we should cover a service that is not covered, you can file an appeal. For information about filing an Appeal, see Page 60.

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan:**

- Services considered not "reasonable and necessary," according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically needed and Medicare pays for it.
- A private room in a hospital, except when it is medically needed.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. Members are still responsible for their cost sharing amounts.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will cover reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Radial keratotomy, LASIK surgery and vision therapy.
- Reversal of sterilization procedures.
- Acupuncture.
- Partial dentures

2.4(B) Integrated Care Program of Illinois (Medicaid Plans)

COVERED SERVICES

The Health Plan shall comply with the terms of 42 C.F.R. §438.206(b) and provide or arrange to have provided to all Members services described in 89 Ill. Adm. Code, Part 140 as amended from time to time and not specifically excluded therein in accordance with the terms of the Contract. Covered Services shall be provided in the amount, duration and scope as set forth in 89 Ill. Adm. Code, Part 140 and the Contract, and shall be sufficient to achieve the purposes for which such Covered Services are furnished. Initially, Covered Services will be phased in as two (2) service packages as follows:

Service Package I.

The Health Plan shall provide, or arrange for the provision of, Covered Services for Service Package I, which includes all of the services and benefits set forth below, to Members at all times during the term of this Certificate, whenever Medically Necessary, except to the extent services are identified as excluded services.

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	Member Pays
Abortions	Termination of pregnancy may be provided only as allowed by applicable State and Federal law and regulation	Covered benefit when necessary to preserve the woman's life or health or when the pregnancy is the result of rape or incest.	$0
Advanced Practice Nurse Covered Services	Medical and preventive services provided by Certified Nurse Midwives, Certified Nurse Practitioners and Certified Pediatric Nurse Practitioners	Covered benefit. Prior authorization and referral may be required.	$0
Ambulatory Surgery	• Preoperative examinations • Operating and recovery room services • All required drugs and medicines	Covered benefit.	$0
Behavioral Health	Behavioral health services including, but not limited to: • Behavioral health assessment and/or psychological evaluation • Medication management • Community treatment and support, including peer specialists or family peer specialist support services • Therapy/counseling • Services in Community Mental Health Centers (CMHC's) • Services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option	Covered benefit. Prior authorization, referral, and other limits may be required.	$0

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	Member Pays
Behavioral Health *(continued)*	Sub-acute alcohol and substance abuse treatment, including, but not limited to: • Outpatient treatment • Residential treatment • Detoxification • Psychiatric evaluation services • Day treatment	Covered benefit. Prior authorization, referral, and other limits may be required.	$0
Chiropractic	Services are limited to the treatment of the spine by manual manipulation to correct a subluxation of the spine.	Covered benefit for members under age 21. Prior authorization and referral may be required. Noncovered services: • Services provided to members 21 years of age and older • Services provided to members in group care facilities by a provider who derives direct or indirect profit from total or partial ownership of such facility • Office visits – Diagnostic or screening • Treatment when a definitive pathology is not present • Maintenance therapy	$0
Cosmetic procedures or surgery	The plan covers cosmetic surgery when it is medically necessary because of accidental injury or to improve the function of a malformed body part.	Medically Necessary covered benefit. Prior authorization and referral may be required.	$0
Dental	• "Practice" visits for members with developmental disabilities or serious mental illness to become more comfortable with the dentist's office. Benefits below are for those under 21 years of age • Oral exams limited to every 6 months in an office setting and one every 12 months in a school setting • Cleanings (once every 6 months) • X-Rays (including bitewings, panoramic film)	Covered benefit. Call DentaQuest toll free at 1-855-343-7400 TTY: 1-800-466-7566 Prior authorization, referral, and other limits may be required.	$0

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	Member Pays
Dental *(continued)*	• Fluoride Treatments (1 per year) • Sealants • Fillings • Crowns • Root canals • Dentures • Maxillofacial Prosthetics • Extractions (pulling) • Space Maintainers • Pulpotomy • Gingivectomy • Scaling & Root Planing • Bridge • Alveoloplasty • Orthodontic Services • Anesthesia • Sedation • Therapeutic Drug Injection Benefits below are for those over 20 • Oral exams (every 6 months) • X-rays(including bitewings, panoramic film) • Prophylaxis cleaning (once every 6 months) • Fillings • Sedation • Crowns • Root Canals • Alveoloplasty • Dentures • Therapeutic Drug Injection • Extractions • Maxillofacial Prosthetics • Anesthesia Pregnant Adults Services necessary for the health of a pregnant woman prior to the delivery of her baby including: Oral exams Prophylaxis Scaling & Root Planing Full mouth debridement to enable comprehensive periodontal evaluation	Covered benefit. Call DentaQuest toll free at 1-855-343-7400 TTY: 1-800-466-7566 Prior authorization, referral, and other limits may be required.	$0

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	Member Pays
Dialysis – Outpatient	Outpatient dialysis treatments	Covered benefit.	$0
Durable and Nondurable Medical Equipment and Supplies	Nondurable medical supplies, including, but not limited to: • Asthma medical supplies such as peak flow meter (not including medicine) • Diabetes testing supplies such as glucometer (not including medicine) Durable medical supplies (DME) including, but not limited to: • Diabetic shoes and inserts • Orthoses • Wheelchairs • Oxygen supplies including respiratory equipment • Apnea monitors	Covered benefit. Prior authorization may be required and other limits may apply. The member must use a medical supply company or pharmacy that is in-network.	$0
Early and Periodic Screening Diagnostic and Treatment Services (EPSDT)	Comprehensive screening, vision, dental, hearing, treatment, immunizations and diagnostic services needed to correct and improve health conditions based on certain federal guidelines.	Covered benefit for members under age 21. Prior authorization and referral may be required.	$0
Emergency Room	You may go to any emergency room if you reasonably believe you need emergency care. Cannot require preauth for ER services.	Covered benefit.	$0
Emergency Transportation	Medically necessary ambulance services	Covered benefit.	$0

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	Member Pays
Eye Care	• Routine eye exam (1 per year) • Glasses (1 pair per year) • Medically necessary contact lenses or glasses • A replacement frame may be covered only when the present frame is broken, and is non-repairable, or has been lost, this includes lenses and frames • New frame parts, including fronts, temples, etc., are covered when used to repair an existing frame • If one or both lenses are broken, but the frame is still usable, the lens or lenses may be replaced Only when Medically Necessary: • Eye exams • Contact lens/lenses and related service • Artificial eye • Low vision devices • Polycarbonate eyeglass lenses for adults, age 21 and over (Polycarbonate lenses for children through age 20 do not require prior approval.)	Covered benefit. Call EyeMed toll free at 1-888-289-0595. Limitations on routine exams: • 1 per year Limitations on contact lenses or glasses: • 1 pair per year for members under age 21 • 1 pair every 2 years for members ages 21 and over	$0
Family Planning	Including, but not limited to: • Provider visit • Birth control and family planning education and counseling • Contraceptives (birth control) • Testing for sexually transmitted diseases and HIV • Sterilization	Covered benefit. Limitations on sterilization include: • Must be age 21 or older • Completed consent form Prior authorization and referral may be required.	$0

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	Member Pays
Hearing Care	Includes: • Basic and advanced hearing tests • Hearing aid related testing and evaluation, hearing aid, counseling, hearing aid fitting. (Replacement is within three years of the initial or previous purchase) • Coverage also includes provision of hearing aid accessories (an average of sixteen [16] batteries per hearing aid in a 60 day period) replacement of parts, and repairs • Provision of a hearing aid must include a minimum of a one-year warranty at no expense to the Plan. • Exception: Payment will not be made for hearing aid batteries for residents in a Long-term-care Facility (LTC). It is the responsibility of the LTC Facility	Covered benefit. The following items or services may be provided only with prior approval: • Binaural hearing aids for adults (individuals over the age of 18) • Monaural hearing aid – creating a binaural situation for adults (individuals over the age of 18) • Hearing aid and dispensing fee – replacement is within three years of the initial or previous purchase • Exceed quantity limits in allotted time frame(s) Repair costs over $250 Prior authorization and referral may be required. Noncovered services include: • Routine periodic exams in the absence of an identified problem • Examination required for the determination of disability or incapacity • Services provided in Federal or State institutions • Expenses associated with postage and handling for any items • Travel expenses to provide testing Services must be medically necessary.	$0
Home Health Care	Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.	Covered benefit. Prior authorization and referral may be required.	$0
Hospital – Inpatient	You are covered for an unlimited number of medically necessary days. Post-stabilization services.	Covered benefit. Prior authorization and referral may be required.	$0

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	Member Pays
Hospital – Outpatient	We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.	Covered benefit. Prior authorization and referral may be required.	$0
Immunizations (Shots)	• Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • We also cover some vaccines under our outpatient prescription drug benefit	Covered benefit. Prior authorization and referral may be required.	$0
Laboratory Services/ X-rays	Medically necessary diagnostic lab services and X-rays	Covered benefit. Prior authorization and referral may be required.	$0
Nurse Midwife Services	Services provided by a nurse midwife for pregnancy and birth	Covered benefit. Prior authorization and referral may be required.	$0
Maternity Care	• Prenatal care (before birth) • Labor and delivery • Postpartum care (after the baby is born)	Covered benefit. Prior authorization and referral may be required.	$0
Nursing Care	Members under the age of 21 can get medically necessary in-home shift nursing and personal care services provided by a registered nurse (RN), licensed practical nurse (LPN) or Certified Nurse's Aide under the direction of a qualified home health agency. Nursing Care for the purpose of transitioning children from a hospital to home placement or other appropriate setting for Enrollees under age 21.	Covered benefit for members under 21 who are not in the HCBS Waiver for individuals who are Medically Fragile Technology Dependent (MFTD) and have extensive medical needs that require ongoing skilled nursing care. The home health agency providing the nursing services must be in our network. Up to a maximum of 120 days for the purpose of transitioning children under age 21. Prior authorization and referral may be required.	$0
Nursing Facility Services	Facility which is duly licensed by the State which provides inpatient acute skilled nursing care, acute rehabilitation services or other related acute health services.	Covered benefit.	$0

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	Member Pays
Organ Transplant	Bone marrow, stem cell, pediatric small bowel and liver/small bowel, heart, heart/lung, lung (single or double), liver, pancreas, kidney/pancreas and other types of transplant procedures may be covered provided the hospital is certified by the department to perform the transplant.	Covered benefit. Prior authorization and referral may be required.	$0
Orthotics/ Prosthetics	Coverage for Prosthetic and Orthotic devices	Covered benefit. Prior authorization and referral may be required.	$0
Palliative and Hospice Services	Services for those that are terminally ill	Covered benefit. Prior authorization and referral may be required.	$0
PCP Visit	Visits to your Primary Care Provider	Covered benefit.	$0
Podiatric Services	Diagnosis and the medical or surgical treatment of injuries and diseases of the feet • Routine foot care for members with certain medical conditions affecting the lower limbs	Covered benefit. Prior authorization and referral may be required.	$0
Prescription and Over-the-counter Drugs	Humana is a mandatory preferred drug plan. A preferred drug is equal to a brand name drug. Preferred drugs are the drugs that we want your provider to prescribe before brand name drugs. Over-the-counter drugs may be covered when prescribed by your provider.	Covered Benefit Prior authorization may be required	30 Day Supply: $2 Generic* $3.90 Brand* $0 Medicaid OTC
Provider Office Visits/ Preventive Care	Includes: • Periodic well adolescent visits (members 19-20) • Well woman visits • Well man visits	Covered benefit. Prior authorization and referral may be required.	$0
Rehabilitative Services	Including, but not limited to: • Occupational therapy • Physical therapy • Speech and language therapy	Covered benefit. Prior authorization and referral may be required.	$0

Covered Services

Humana Integrated Care Program of Illinois covers all Illinois Medicaid services.

Type of Care	Covered Services	Coverage and Benefit Limitations	Member Pays
Radiology	Diagnostic and therapeutic radiology services	Covered benefit. Prior authorization and referral may be required.	$0
Screening Assessment and Support Services (SASS)	Crisis intervention program for enrollees under 21.	Covered benefit. Under 21.	$0
Transportation Services	$0 copayment for plan-approved locations up to unlimited round trip(s) per year by taxi, bus/subway, van, medical transport	Trips allowed to pharmacies right after your doctor's visit, nursing homes and other covered services.	$0

Excluded Services

The following services are not Covered Services:

- Services that are provided in a State Facility operated as a psychiatric hospital as a result of a forensic commitment;
- Services that are provided through a Local Education Agency (LEA);
- Services that are experimental or investigational in nature;
- Services that are provided by a non-Affiliated Provider and not authorized by Health Plan, unless the Contract specifically requires that such services be Covered Services;
- Services that are provided without a required Referral or prior authorization as set forth in the provider handbook;
- Medical and surgical services that are provided solely for cosmetic purposes; and
- Diagnostic and therapeutic procedures related to infertility or sterility.

Limitations on Covered Services

The following services and benefits shall be limited as Covered Services:

- Termination of pregnancy may be provided only as allowed by applicable State and Federal law (42 C.F.R. Part 441, Subpart E). In any such case, the requirements of such laws must be fully complied with and HFS Form 2390 must be completed and filed in the Member's medical record. Termination of pregnancy shall not be provided to Members who are eligible under the State Children's Health Insurance Program (215 ILCS 106).
- Sterilization services may be provided only as allowed by State and Federal law (see 42 C.F.R. Part 441, Subpart F). In any such case, the requirements of such laws must be fully complied with and a HFS Form 2189 must be completed and filed in the Member's medical record.
- If a hysterectomy is provided, a HFS Form 1977 must be completed and filed in the Member's medical record.

Services Not Covered by the Health Plan

Here are some additional services that the Health Plan does not cover. These services are also not covered by Illinois Medicaid. For more information call Member Services at 1-800-764-7591.

- Experimental or research-oriented procedures
- Elective Cosmetic procedures or surgery
- Infertility testing and treatment; artificial insemination
- Consultation requested by a third party or agency
- Acupuncture
- Medical examinations required for adult educational or vocational program
- Any service that you can get without charge from state and/or local health agencies
- Services that are prohibited by State or Federal law
- Autopsy examinations
- Missed appointments
- Preparation of routine records, forms and reports
- Medical visits with any person that is not the patient
- Items or services that are not medically necessary
- Services provided without a required referral or prior authorization
- Elective abortion
- Medical care provided by mail or telephone, except for approved Telemedicine services
- Services from providers who are no longer in our network
- Partial dentures

LTSS Covered Services

Humana Gold Plus Integrated (Medicare-Medicaid Plan)
Humana Integrated Care Program of Illinois.

Type of Care	Covered Services	Coverage and Benefit Limitations	Member Pays
Adaptive Equipment	This service includes devices, controls, or appliances, specified in the plan of care, which enable the member to increase his or her abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Adult Day Services	This is a daytime community-based program for adults not living in Supported Living Facilities. Adult Day Service provides a variety of social, recreational, health, nutrition, and related support services in a protective setting. Transportation to and from the center and lunch are included as part of this service.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Behavioral Services	These services are behavioral therapies designed to assist members with brain injuries in managing their behavior and thinking functions, and to enhance their capacity for independent living.	Waiver eligibility required. Prior authorization and referral may be required.	$0

LTSS Covered Services

Humana Gold Plus Integrated (Medicare-Medicaid Plan)
Humana Integrated Care Program of Illinois.

Type of Care	Covered Services	Coverage and Benefit Limitations	Member Pays
Day Habilitation	This service provides members with brain injuries training with independent living skills, such as help with gaining, maintaining, or improving self-help, socialization, and adaptive skills. This service also helps the member to gain or maintain his or her maximum functional level.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Personal Emergency Response System	This electronic equipment allows members 24-hour access to help in an emergency. The equipment is connected to your phone line and calls the response center and/or other forms of help once the help button is pressed.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Personal Emergency Response System	This electronic equipment allows members 24-hour access to help in an emergency. The equipment is connected to your phone line and calls the response center and/or other forms of help once the help button is pressed.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Environmental Accessibility Adaptations	These are physical modifications to a member's home. The modifications must be necessary to support the health, welfare, and safety of the member and to enable the member to function with greater independence in his or her home. Without the modification a member would require some type of institutionalized living arrangement, such as nursing facility or assisted living. Adaptations that do not help the member's safety or independence are not included as part of this service, such as new carpeting, roof repair, central air, or home additions.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Home-delivered Meals	Prepared food brought to the member's home that may consist of a heated lunch meal and a dinner meal (or both), which can be refrigerated and eaten later. This service is designed for the member who cannot prepare his or her own meals but is able to feed him/herself.	Waiver eligibility required. Prior authorization and referral may be required.	$0

LTSS Covered Services

Humana Gold Plus Integrated (Medicare-Medicaid Plan)
Humana Integrated Care Program of Illinois.

Type of Care	Covered Services	Coverage and Benefit Limitations	Member Pays
Home Health Aide	A person who works under the supervision of a medical professional, nurse or physical therapist, to assist the member with basic health services such as assistance with medication, nursing care, physical, occupational and speech therapy.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Homemaker	In-home caregiver hired through an agency. The caregiver helps with housekeeping items such as meal preparation, shopping, light housekeeping, and laundry. The caregiver can also help with hands-on personal care items such as personal hygiene, bathing, grooming and feeding.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Nursing-Skilled	This service provides skilled nursing services to a member in his or her home for short-term acute healing needs, with the goal of restoring and maintaining a member's maximal level of function and health. These services are provided instead of a hospitalization or a nursing facility stay. A doctor's order is required for this service.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Nursing – Intermittent	This service focuses on long-term needs rather than short-term acute healing needs, such as weekly insulin syringes or medi-set set up for members unable to do this for themselves. These services are provided instead of a hospitalization or a nursing facility stay. A doctor's order is required for this service.	Waiver eligibility required. Prior authorization and referral may be required.	$0

LTSS Covered Services

Humana Gold Plus Integrated (Medicare-Medicaid Plan)
Humana Integrated Care Program of Illinois.

Type of Care	Covered Services	Coverage and Benefit Limitations	Member Pays
Personal Assistant	In-home caregiver hired and managed by the member. The member must be able to manage different parts of being an employer such as hiring the caregiver, managing their time and timesheets, completing other employee paperwork. The caregiver helps with housekeeping items such as meal preparation, shopping, light housekeeping, and laundry. The caregiver can also help with hands-on personal care items such as personal hygiene, bathing, grooming, and feeding. Personal Assistants can include other independent direct care givers such as RNs, LPNs, and Home Health Aides.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Physical, Occupational and Speech Therapy	Services designed to improve and or restore a person's functioning; includes physical therapy, occupational therapy, and/or speech therapy.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Prevocational Services	This service is for members with brain injuries and provides work experiences and training designed to assist individuals in developing skills needed for employment in the general workforce. Services include teaching concepts such as compliance, attendance, task completion, problem-solving and safety.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Respite	This service provides relief for unpaid family or primary caregivers who are meeting all the needs of the member. The respite caregiver assists the member with all daily needs when the family or primary caregiver is absent. Respite can be provided by a homemaker, personal assistant, nurse or in an adult day services center.	Waiver eligibility required. Prior authorization and referral may be required.	$0
Supported Employment	Supported employment includes activities needed to maintain paid work by individuals receiving waiver services, including supervision and training.	Waiver eligibility required. Prior authorization and referral may be required.	$0

LTSS Covered Services

Humana Gold Plus Integrated (Medicare-Medicaid Plan)
Humana Integrated Care Program of Illinois.

Type of Care	Covered Services	Coverage and Benefit Limitations	Member Pays
Supportive Living Program	An assisted living facility is a housing option that provides members with many support services to meet the member's needs to help keep the member as independent as possible. Examples of support services to meet those needs include: housekeeping, personal care, medication oversight, shopping, and social programs. Supportive Living does not offer complex medical services or supports.	Waiver eligibility required. Prior authorization and referral may be required.	$0

3. Emergency Service Responsibilities

Participating Providers are required to ensure adequate accessibility for healthcare 24 hours per day, seven days per week. An after-hours telephone number must be available to Members (voice mail is not permitted). Members should go to the closest emergency room or any other emergency setting if they have an emergency such as 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

Members are instructed to call their PCP as soon as possible when they are in a hospital or have received emergency care.

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

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

Members 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, Members should call their PCP as soon as possible.

3.1 Emergency Mental Health Services

For behavioral health services, please instruct Members to contact Humana at 1-855-235-8579.

For emergency behavioral healthcare within or outside the service area, please instruct Members 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 behavioral 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

4. Model of Care and Care Coordination

Overview of the CMS-Approved Model of Care:

Humana's program will provide a proactive and comprehensive system of care for Members living with chronic physical diseases, mental illness, substance use disorders and/or developmental and intellectual disabilities that promotes person-centered, integrated care across the spectrum of medical, behavioral, psycho-social and long term services and supports. This approach is aimed at eliminating fragmented and often poorly coordinated healthcare and social services that historically plague the effective treatment for these individuals and result in poor health status and ineffectual expenditures.

In addition to focusing on the Member's experience, Humana's Model of Care provides appropriate utilization of services and ensures cost-effective health services delivery.

The Provider's participation is key and includes the following activities:

- Participation in Interdisciplinary Care Team (ICT) care conferences via phone, through exchange of written communications and possibly in person
- Participation in inbound and outbound communications to foster care coordination
- Promote Healthcare Effectiveness Data and Information Set (HEDIS®) and National Committee for Quality Assurance (NCQA) quality measures
- Provide all medical record documentation and information as requested to support Humana's fulfillment of State and Federal regulatory and accreditation obligations, e.g., HEDIS.

Continuity of Care

Humana offers an initial one hundred eighty (180)-day transition period for Members new to the Demonstration in which Members may maintain a current course of treatment with a Provider who is currently out of network. Humana offers a ninety (90)-day transition period for Members switching from another Demonstration Plan to Humana. The one hundred eighty (180)-day and ninety (90)-day transition periods are applicable to all Providers, including behavioral health Providers and Providers of LTSS. Out-of-network PCPs and specialists providing an ongoing course of treatment will be offered single case agreements to continue to care for that Member beyond the transition period if they remain outside the network or until a qualified affiliated Provider is available.

Out-of-Network Providers

In the event that the Physician of a new Member who is in an active, ongoing course of treatment or is in the third trimester of pregnancy is not a Participating Provider, Humana will permit the Member to continue an ongoing course of treatment with such Physician for up to ninety (90) days or through the postpartum period, or as otherwise required by Section 25 of the Managed Care Reform and Patients' Rights Act only if the out-of-network Physician agrees to provide such ongoing course of treatment, and if such out-of-network Physician agrees to: (i) accept reimbursement at Humana's established rates based on a review of the level of services provided, (ii) adhere to Humana's QA requirements, (iii) provide necessary medical information related to healthcare, and (iv) adhere to Humana's policies and procedures, including, but not limited to, procedures regarding Referrals.

Provider's Role and Responsibility in Care Coordination, Care Transitions, Comprehensive Medication Reviews and Preventive Screenings:

- Deliver evidence-based medical management addressing the Members' needs, choices and cultural preferences
- Assure that Members are informed of specific healthcare needs requiring follow-up and that Members receive training in self-care, including medication adherence, and other measures they may take to promote their own health
- Ensure the Member receives appropriate specialty, ancillary, emergency and hospital care when needed, providing necessary referrals and communicating to Specialists, Hospitalists, SNF, and other Providers, Member information that will assist them in consultation and recommending treatments, equipment and/or services for the Member
- Provide coordination of care for Members who are homebound or have significant mobility limitations to ensure access to care through home visits by nurse practitioners or physicians
- Track and document appointments, clinical findings, treatment plans and care received by Members referred to specialists, other healthcare Providers or agencies to ensure continuity of care
- Obtain authorizations and notify Humana for any out-of-network services when an in-network Provider of the specialty in question is not available in the geographical area.
- Work with Humana's Care Coordination team to arrange for a Member to receive a second opinion, when the Member requests one, from a qualified in-network healthcare professional or arrange for the Member to obtain one outside the network, if a qualified in-network Provider is not available.
- Initiate or assist with the discharge or transfer of Members from an inpatient facility to the most medically appropriate level of care facility or back to the Member's home or permanent place of domicile; consider the availability of in-network facilities and obtain appropriate authorizations if using out-of-network facilities.
- Cooperate and communicate with other service providers who serve Enrollees. Such other service providers may include: special Supplemental Nutrition Programs for Women, Infants, and Children (commonly referred to as "WIC" programs), Head Start programs; Early Intervention programs, and schools systems. Such cooperation may include performing annual physicals for school and sharing of information with the consent of the enrollee.
- Support, participate in, and communicate with the ICT, in person and/or in writing, in developing and implementing an individualized plan of care in order to facilitate effective care coordination.
- Provide timely access to medical records or information for quality management and other purposes, including audits, reviews of Complaints or Appeals, HEDIS, and other studies, and promptly respond to recommendations for improvement by developing and enacting a corrective/improvement plan, as appropriate
- Follow the preventive care guidelines set by the U.S. Preventive Services Task Force, and provide and document the preventive care services required by the NCQA for HEDIS Quality Assurance Reporting Requirements.
- Acknowledge that out-of-network or other authorizations are limited to the terms of the authorization as part of the Member's ongoing course of treatment in accordance with continuity-of-care guidelines consistent with State requirements
- Adhere to preauthorization and referral processes and procedures
- Within 24 hours of discharge from an inpatient facility, transmit the transition record (discharge instructions) to the facility, primary care provider or other health care professional designated for

follow-up care, including the diagnosis, treatment and care plan."

Note: For Members, other than those who reside in nursing facilities:

a. The Member maintains his or her current Providers for 180 days from the effective date of enrollment or 90 days if changing Health Plans

b. During the 180-day transition period, the Member's existing Provider may be changed, but only under the following circumstances:

- The Member requests a change;
- The Provider chooses to discontinue providing services to a Member as currently allowed by Medicare or Medicaid; or
- Humana, CMS or the State identifies Provider performance issues that affect a Member's health and welfare.

Provider Creation and Participation in Individualized Care Plans – The Individualized Care Plan is based on:

- Initial and ongoing Health Risk Assessment (HRA) and comprehensive assessment results
- Claims history
- Plans developed for each Member by the ICT
- Include Member-driven short-term and long-term goals, objectives and interventions
- Address specific services and benefits
- Provide measurable outcomes

Provider Participation as an Integral Member of the ICT:

The ICT is a team of caregivers from different professional disciplines who work together to deliver care services focused on care planning to optimize quality of life and to support the individual and/or family. The ICT may include:

- The Member and/or his or her authorized caregiver
- The Member's physicians and/or nurses
- Humana's care coordinators
- Social workers and community social-service Providers
- Humana's and/or the Member's behavioral health professionals
- Humana's community health educators and resource-directory specialists

The physician-inclusive ICT model supports the following:

- The physician's treatment and medication plans
- The physician's goals via the Humana care management team of nurses, social workers, pharmacy specialists and behavioral-health specialists
- Member education and enhancement of direct patient-physician communication
- Self-care management and informed healthcare decision-making
- Care coordination and care transitions
- Access and connections to additional community resources
- Coordination of Medicare and Medicaid benefits and services including Long Term Support Services (LTSS)
- Appropriate advance illness and end-of-life planning

Illinois law allows for the following two types of advance directives: (1) healthcare power of attorney; and (2) written healthcare directive (also known as a living will). Providers should ensure that Members are informed of these rights.

Expected Provider Communications and Reporting:

- Maintain frequent communication, in person or by phone, with the ICT including other Providers of care and services such as specialist physician, hospital and/or ancillary Providers to ensure continuity of care and effective care coordination
- Immediately report actual or suspected child abuse, elder abuse or domestic violence to the local law enforcement agency by telephone and submit a follow-up written report to the local law enforcement agency within the time frames as required by law
- Provide all medical record documentation and information as requested to support Humana's fulfillment of State and Federal regulatory and accreditation obligations, e.g., HEDIS and NCQA, including access to electronic health records, as applicable

Note: Additional Member information will be added regarding care plans, assessments and Member Summaries and made available on Humana's website, Provider's section.

Working with Demonstration and ICP Members With a Mental Health Diagnosis:

- Facilitate referral of the Member to specialists or specialty care, behavioral healthcare services, health education classes and community resource agencies, when appropriate
- Integrate medical screening along with basic primary care services provided to Demonstration and ICP Members; provide screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders
- Deliver evidence-based behavioral health treatment and establish protocols for referral to behavioral health specialty Providers
- Ensure confidentiality of Members' medical and behavioral health and personal information as required by State and Federal laws

Understanding Chronic Conditions Prevalent within the Demonstration and ICP population:

- Multiple chronic conditions increase the risks for poor outcomes such as mortality and functional limitations as well as the risk of high-cost services such as hospitalizations and emergency room visits. Evidence proves that preventive care and frequent/consistent care of chronic conditions lowers the advent of major conditions and decreases use of emergency room visits and readmissions.
- Humana's Clinical Practice Guidelines, available to both affiliated and nonaffiliated Providers on Humana's website, incorporate relevant, evidence-based medical and behavioral health guidelines (preventive and certain nonpreventive acute and chronic conditions) from recognized sources such as professional medical associations, voluntary health organizations and NIH Centers and Institutes.
- Humana provides chronic disease management services and support to promote self-management for individuals with chronic conditions.

Importance of Coordinating Both Medicare and Medicaid Benefits, Including Information on Long Term Service Support (LTSS) Medicaid Benefits:

- Member-centered, coordinated care – Person-centered and collaboratively planned care by a care team with knowledge about the specific needs of the Member and the array of medical, nonmedical and behavioral services and benefits available to meet those needs are critical to helping the Member achieve their optimum level of wellness.
- Many dually eligible Members require a broad range of LTSS and community support in order to meet their functional needs. Effective coordination and administration of LTSS benefits and easy access to these services help assure that these needs are adequately met and reduce the reliance on less

appropriate and more costly emergency or hospital-based care.

- Demonstration and/or ICP Members are faced daily with a variety of life challenges. Humana aims to eliminate the challenges and frustration of navigating a complex healthcare system by integrating a variety of administrative processes for Members and Providers.

5. Provider Complaints

For all inquiries, including Complaints, please contact Humana customer service at 1-800-457-4708 or your Network Management Consultant. Based on the type of issue or Complaint, your inquiry will be reviewed by the Humana associate with the designated authority to resolve your issue or Complaint.

Provider Appeal rights for audits are outlined on Humana's website under the Provider section, Provider Education for Clinical Audit Appeals.

6. Grievance and Appeals System

The section below is taken from Humana's Member Grievance and Appeal procedure as set forth in the Humana Member Handbook. This information is provided to you so that you may assist Humana Members in this process should they request your assistance. Please contact your Network Management Consultant should you have questions about this process.

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

Filing a Grievance or an Appeal

If you have questions or an issue, call Humana Customer Care at 1-800-787-3311.

If you are not happy with the answer you get from customer care, you can fi a Grievance or an Appeal. You can get a form or you can send a letter to Humana. If you request a form from Humana, it will be mailed within three working days. You can also request help from Humana to fi out the form.

The member can have someone help during the grievance or appeal process, whether it is a Provider or an authorized person.

The Grievance/Appeal must have the following:

- Member's name, address, telephone number and ID number
- Facts and details of what you did to straighten out this Complaint
- What action you are looking for
- Signature
- Date

Grievance: The member has the right to make a written or verbal Grievance at any time. The Grievance process may take up to 30 calendar days for the MMAI plan, and 90 calendar days for the ICP plan. However, Humana will resolve the member's Grievance as quickly as the member's health condition requires. For the MMAI plan, a letter telling the Member the outcome of the Grievance will go out within 90 calendar days from the date Humana receives the request. For the ICP plan, a letter telling you the outcome of your Grievance will go out within 90 calendar days from the date Humana receives your request. A letter advising of the outcome of the Grievance will be sent to the member and/or the authorized representative.

Appeal: You have the right to make a written or verbal Appeal within 60 calendar days of the date you receive a written denial. If you file a verbal appeal request, you must also submit the request in writing. The Appeal process may take up to 15 business days. However, Humana will resolve the Appeal as quickly as your health condition requires, but no later than 15 business days from the request. A letter telling you the outcome of your Appeal will be sent to the Member and/or the Member's authorized representative within 15 business days from the date Humana receives the request. If more time is needed, the Member and Humana must agree on it. If other information is needed, Humana will have 14 extra days to make a decision. Humana will send you a letter telling you about the extra time. The Member has the right to continue services during the Appeal and Medicaid Fair Hearing process. If the Member chooses to continue the services and the decision of the Appeal is not in the Member's favor, the Member may have to pay for those services. Note: The Humana Appeal Process must fi be exhausted before fi for a Medicaid State Fair Hearing.

Expedited Appeal Process: You have the right to make verbal or written expedited Appeal. If you have a problem that is putting your life or health in danger, you or your legal spokesperson can file an "urgent" or "expedited" Appeal. These Appeals are handled within 24 hours of receipt of all the required information to work the Appeal. Let the person you are talking to know that this is an "urgent" or "expedited" Appeal. You may request an expedited Appeal by calling Humana. For Medicare-Medicaid plans, call 1-800-787-3311. For Medicaid plans, call 1-800-764-7591. If it is determined that it is not an expedited process, it will go through the standard appeal process.

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

Humana Medical Plan Inc.
Attn: Grievance and Appeal Department
Illinois MMAI & ICP
P.O. Box 14546
Lexington, KY 40512-4546

If you wish to contact Humana's Customer Care department by phone, please call 1-800-787-3311. If you cannot hear or have trouble talking, call 711. We are open from 8 a.m – 7 p.m. Monday – Friday.

You can call the Illinois Department of Healthcare and Family Services toll free 1-800-435-0774 (voice) or 1-877-734-7429 (TTY), Monday – Friday, between 8:30 a.m. – 4:45 p.m.

7. Chronic and Complex Conditions

7.1 Comprehensive Diabetes Care.

Diabetic Retinal Examinations. Humana is committed to reducing the incidence of diabetes-induced blindness in Humana Members. Early intervention and continual monitoring of diabetic eye disease could reduce the incidence of diabetes-related blindness. Based on guidelines proposed by the American College of Physicians, the American Diabetic Association, and the American Academy of Ophthalmology, the Humana PCP 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 a Member's blood sugar is controlled. Consistent with the American Diabetic Association recommendations, the Humana primary care Provider will provide or manage services such that Members 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 PCP will provide or manage services such that Members with a history of diabetes will receive lipid and lipoprotein determinations annually. If any anomalies are found in the annual baseline, additional studies should be conducted as Medically Necessary.

7.2 Nephropathy.

The Humana PCP 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 PCP will manage the Member by identifying evidence of a positive test for protein in the urine (micro-albuminuria testing). Member is to be monitored for the disease, including end-stage renal, chronic renal failure and renal insufficiency or acute renal failure and referred to a nephrologist as deemed medically appropriate.

7.3 Congestive Heart Failure.

Humana is aware that today 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 PCP will provide or manage care of the CHF Member 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 Member should be instructed on nutrition and education ongoing of his or her disease.

7.4 Asthma.

Humana recognizes that asthma is a common chronic condition that affects individuals of all ages. The PCP will be expected to measure the Member's lung function and assess the severity of asthma and to monitor the course of therapy based on the following:

1. Educate the Member 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 Member, his or her family and clinicians.

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

7.6 HIV/AIDS. Humana requires that PCPs assist Members in obtaining necessary care in coordination with Humana Health Services staff. Please contact Humana Health Services at 1-855-235-8579 or your Provider contract representative for more details.

7.7 HEDIS® Care of Older Adult (COA) Measures (applies to MMAI Program only). Humana recognizes that identification of issues related to medications, activities of daily living, and pain management are important evaluations for special needs Members. The PCP is expected to assess the Member's functional status assessment, current medications, a pain assessment, and discussion regarding advanced care planning. The PCP is also be expected to address any issues that are identified and make referrals to appropriate case management and/or disease management programs.

8. PCP and Other Provider/Subcontractor Responsibilities

8.1 Access to Care

MMAI Demonstration:

Participating PCPs and specialists are required to ensure adequate accessibility for healthcare 24 hours per day, seven days per week. An after-hours telephone number must be available to Members (voice mail is not permitted). Members should be triaged, and provided appointments for care within the following time frames.

Urgent Care: Member must be provided an appointment within one business day when medically necessary.

Routine Sick Member Care: Member must be provided an appointment within seven days of making a request.

Well Care and Routine Visits: Member must be provided an appointment within five weeks of making a request.

Problems or Complaints (not deemed serious): Member must be provided an appointment within three weeks of making a request.

Initial Prenatal Visits without expressed problems:

- Presenting in first trimester, Member must be provided an appointment within two weeks of request.
- Presenting in second trimester, Member must be provided an appointment within one week of request.
- Presenting in third trimester, Member must be provided an appointment within three days of request.

ICP:

Participating PCPs and specialists are required to ensure adequate accessibility for healthcare 24 hours per day, seven days per week and shall offer hours of operation that are no less than the hours of operation offered to persons who are not Members. An after-hours telephone number must be available to Members (voice mail is not permitted). Members should be triaged, and provided appointments for care within the following time frames.

Urgent Care (Nonemergent): If necessary or appropriate, Members must be immediately referred for urgent Medically Necessary care or provided with an appointment within one (1) business day of the request.

Routine Sick Member Care: Member must be provided an appointment within three days of making a request.

Well Care and Routine Visits: Member must be provided an appointment within five weeks of making a request.

Problems or Complaints (not deemed serious): Member must be provided an appointment within three weeks of making a request.

Initial Prenatal Visits without expressed problems:

- Presenting in first trimester, Member must be provided an appointment within two weeks of request.
- Presenting in second trimester, Member must be provided an appointment within one week of request.
- Presenting in third trimester, Member must be provided an appointment within three days of request.

8.2 Patient-centered Medical Home

Participating patient-centered medical homes are required to manage and provide evidence-based services to Members in order to integrate care with specialty and subspecialty practices. The medical home is required to adhere to the following:

1. **Enhance Access and Continuity:** Accommodate Member's needs with access and advice during and after hours, give patients and their families information about their medical home and provide Members with team-based care.

2. **Identify and Manage Patient Populations:** Collect and use data for population management.

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

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

5. **Track and Coordinate Care:** Track and coordinate tests, referrals and transitions of care.

6. **Measure and Improve Performance:** Use performance and patient experience data for continuous quality improvement

For more information on how your practice can become a Patient-centered Medical Home, contact Humana IL Provider Contracting at 1-312-441-9111.

8.3 Americans with Disabilities Act (ADA) Compliance

Providers are required to comply with all ADA requirements including utilization of waiting room and exam room furniture and accessible routes to and through rooms that meet needs of all Members, including those with physical and nonphysical disabilities, use of clear signage throughout Provider offices and provide adequate handicapped parking.

In order to help our provider partners with this important requirement, Humana associates, or associates of a designated vendor operating on behalf of Humana, may perform physical inspection of provider office locations as one of the steps to help ensure compliance with ADA requirements.

8.4 Member Special Needs Consideration

Providers make efforts to understand the special needs required by Members. The Member may have challenges that include physical compromises as well as cognitive, behavioral, social and fi issues. Multiple co-morbidities, complex conditions, frailty, disability, end-of-life issues, end-stage renal disease, isolation, depression, and polypharmacy are some of the challenges facing these Members each day.

Recognizing the signifi ant needs of Members, Humana incorporates all of the principles of multi-disciplinary integration, as well as person-centered care planning, coordination and treatment in our care coordination program.

1. Integrated care management is delivered within an ICT structure and holistically addresses the needs of each Member.

3. The Member and/or their authorized caregiver are maintained at the core of the Model of Care ensuring person-centered care and supported self-care.

3. Each Member is assigned a Care Coordinator who leads the Member's ICT and links closely to the Members' PCP to support them in ensuring Members get the care needed across the full spectrum of medical, behavioral health, and long-term care services.

- Humana's predictive model based on claims history and analytics is used to determine each Member's risk level and level of intervention required in order to channel them to the required level of coordination.
- The mDAT, a scored and weighted assessment tool, produces a clinically sound "snapshot in time" or profile of the Member's health status. The mDAT provides an overall risk score which, combined with the predictive model score, is used to direct interventions targeted to impactable concerns.
- The Member is encouraged to participate in all aspects of care management and coordination, including in the development of an individualized care plan. The Care Coordinator and ICT ensure that the Member receives any necessary assistance and accommodations, including those mandated by the ADA, to prepare for and fully participate in care planning and throughout the care management process. The team, furthermore, assures that the Member receives clear information about:
    - His or her health conditions and functional limitations;
    - How family members and social supports can be involved in the care planning as the Member chooses;
    - Self-directed care options and assistance available to self-direct care;
    - Opportunities for educational and vocational activities; and
    - Available treatment options, supports and/or alternative courses of care.

Identifying Barriers to Care Encountered by the Demonstration Population

- Different programs with diverse coverage and payment structures impact delivery of integrated care due to poor coordination of services and benefits resulting in fragmented care not focused on the Member's needs.
- Shortage of health professionals in rural areas and inner cities affect easy access by Demonstration and ICP Members to quality and cost-effective care and preventive services.
- Organizational barriers, including lack of interpreter services, wheelchair accessibility, and long appointment wait times, cause frustration and, potentially, refusal by the Member to seek and participate in their care.
- Lack of coordination between behavioral health and other medical and nonmedical services not parallel.
- Cultural and religious beliefs impact Member health beliefs and behaviors including relationships with their Providers and compliance to recommended treatments.
- Socioeconomic status may present issues related to poor education and lack of knowledge and support affecting such concerns as awareness of available health options and support, reinforcement of healthy behaviors, and ability to pay out of pocket.
- Lack of permanent residence or place of domicile for some of the Members impact the ability of care Providers to engage and provide education and support to these Members.

8.5 Family Planning Services

Any Provider can provide family planning services to a Member without receiving preauthorization for such services. In addition, Providers should make available and encourage all pregnant women and mothers with infants to receive postpartum visits for the purpose of voluntary family planning, which may include a discussion of all appropriate methods of contraception, counseling and services for family planning. Providers furnishing such family planning services to Members must document the offering and provision of family planning services in the Member's medical records. This provision should not prevent a healthcare Provider from refusing to furnish any contraceptive or family planning service, supplies or information for medical or religious reasons.

8.6 Immunizations

Immunizations should be provided in accordance with the Recommended Childhood Immunization Schedule for the United States or when Medically Necessary for the Member's health, as determined by the physician. Providers should participate in the Vaccines for Children Program (VFC) as described in Section 1905 (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.

8.7 Adult Health Screening

Adult Preventive Health Exam – Beginning at Age 21 Years

Elements:	Guidelines
1. Risk Screening	Screening to identify high-risk individuals, assessing family medical and social history is required. Screening for the following risks are included as a minimum: cardiovascular disease, hepatitis, HIV/AIDS, STDs and TB.
2. Interval History	Interval histories are required with preventive healthcare. Changes in medical, emotional and social status are documented.
3. Immunizations	Immunizations are documented and current. If immunization status is not current, this is 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 healthcare 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	Screening required every five years for: – Men, beginning at age 35 – Women, beginning at age 45 (Earlier if there is any risk factor evident for cardiovascular disease)
8. Visual Acuity Testing	Visual acuity testing, at a minimum, documents the patient's ability to see at 20 feet. Referrals for testing must be documented.
9. Hearing Screening	Test or inquire about hearing periodically/once a year.
10. Electrocardiogram	Periodically after age 40-50 (or as primary care provider deems medically appropriate)
11. Colorectal Cancer Screening	Colorectal cancer screening must be documented Screening beginning at age 50. **Risk Factors:** First-degree relatives or personal history of colorectal cancer, personal history of female genital or breast cancer, familial adenomatous polyposis, Gardner's syndrome, hereditary nonpolyposis colon cancer, chronic inflammatory bowel disease.
12. Pap Smear	Baseline pap smears 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 has had regularly normal smears up to that age.
13. Mammography	Required as appropriate between ages 35 and 40. – 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	U.S. Preventive Services Task Force/December 2002: The evidence is insufficient to recommend for or against routine screening for prostate cancer using PSA testing or digital rectal examination. The USPSTF found good evidence that PSA can detect early-stage prostate cancer but mixed, inconclusive evidence that early detection improves health outcomes. 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 50–69 year-olds, provided that the risks, benefits and uncertainties are understood. With the current available evidence, it is diffi to ever justify routine screening of men 70 and older.
15. Education/Anticipatory Guidance	Health education and guidance must be documented. Guidance 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; begin at age 60 if at increased risk for osteoporotic fractures. Perform a bond density scan (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.

8.8 Hysterectomies, Sterilizations and Abortions

Providers must maintain a log of all hysterectomy, sterilization and abortion procedures performed on Members. The log must include, at a minimum, the Member's name and identifying information, date of procedure and type of procedure. The 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.

8.9 Pregnancy-related Requirements

Licensed health care professionals providing prenatal care must provide education to women and, if possible and with permission, to families about perinatal behavioral health disorders. Providers should invite women to complete a questionnaire to assess whether they suffer from perinatal behavioral health disorders, using an approved instrument such as the Edinburgh Postnatal Depression Scale.

Providers are expected to remind women of the importance of receiving their postpartum exam, and developing a reproductive plan, including birth control. Providers should promote regular preventive care through annual preventive health and family planning visits.

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

(1) Providers should offer all pregnant women counseling and HIV testing at the initial prenatal care visit and again at 28 to 32 weeks.

(2) Providers must attempt to obtain a signed objection if a pregnant woman declines an HIV test.

(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.

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

Providers should ensure that infants born to HBsAg-positive Members 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 Maxine 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 Members 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 aged 24 months or less within 24 hours of receipt of the positive test results.

Providers should report to the Perinatal Hepatitis B Prevention Coordinator at the local CHD all prenatal or postpartum Members who test HBsAg-positive. Participating Providers should also report said Members' infants and contacts to the Perinatal Hepatitis B prevention coordinator at the local CHD.

(1) Providers 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 Member received prenatal care, and immunization dates for infants and contacts.

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

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

(1) Prenatal Care – Providers are expected to:
   i) Require a pregnancy test and a nursing assessment with referrals to a physician, physician assistant, or Advanced Practice Nurse (APN) for comprehensive evaluation;

   ii) Require case management through the gestational period according to the needs of the Member;

   iii) Require any necessary referrals and follow-up;

   iv) 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 Member's condition requires more frequent visits;

   v) Contact those Members who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care;

vi) Assist Members in making delivery arrangements, if necessary; and

vii) Ensure that all pregnant Members are screened for tobacco use and make available to the pregnant Members smoking cessation counseling and appropriate treatment as needed.

(2) Nutritional Assessment/Counseling – Providers should supply nutritional assessment and counseling to all pregnant Members. In addition, Providers are expected to:

i) Ensure the provision of safe and adequate nutrition for infants by promoting breastfeeding and the use of breast milk substitutes;

ii) Offer a mid-level nutrition assessment;

iii) Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or physician following the nutrition assessment; and

iv) Document the nutrition care plan in the medical record by the person providing counseling.

Providers are required to immediately notify Humana of a Member's pregnancy by calling 1-855-235-8579, whether identified through medical history, examination, testing, claims, or otherwise.

If a Member becomes pregnant while on the Health Plan, she is requested to call Humana Beginnings at 1-888-847-9960. She should choose a Humana obstetrician for her care, and make an appointment to see this doctor as soon as possible. She must also notify the Department of Children and Family (DCF) of the pregnancy by calling 1-800-232-3798 (Advocacy Office).

(1) Obstetrical Delivery – The Health Plan shall develop and use generally accepted and approved protocols for both low-risk and high-risk deliveries reflecting the highest standards of the medical profession, including Healthy Start and prenatal screening, and ensure that all Providers use these protocols:

(i) The Health Plan shall ensure that all Providers document preterm delivery risk assessments in the Member's medical record by week twenty-eight (28).

(ii) If the Provider determines that the Member's pregnancy is high risk, the Health Plan shall ensure that the Member's obstetrical care during labor and delivery includes preparation by all attendants for symptomatic evaluation and that the Member progresses through the final stages of labor and immediate postpartum care.

(2) Postpartum Care – The Health Plan shall:

(i) Provide a postpartum examination for the Member within six (6) weeks after delivery.

(ii) Ensure that its Providers supply voluntary family planning, including a discussion of all methods of contraception, as appropriate.

8.10 Domestic Violence, Alcohol and Substance Use, and Smoking Cessation

8.10.1 PCPs should screen Members for signs of domestic violence and should offer referral services to applicable domestic violence prevention community agencies. See Quality Enhancement section 8.11, below.

8.10.2 PCPs should screen Members for signs of alcohol and substance use as part of

prevention evaluation at the following times:

(a) Upon initial contact with Member;

(b) During routine physical examinations;

(c) During initial prenatal contact;

(d) When the Member shows evidence of serious over-utilization of medical, surgical, trauma or emergency services; and

(e) When documentation of emergency room visits suggests the need.

8.10.3 PCPs should screen and educate Members regarding smoking-cessation by:

(a) Making Members aware of and recognizing dangers of smoking;

(b) Teaching Members how to anticipate and avoid temptation;

(c) Providing basic information to the Member about smoking and successfully quitting;

(d) Encouraging the Member to quit; and

(e) Encouraging the Member to talk about the quitting process.

8.11 Quality Improvement Requirements

Humana will monitor and evaluate the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to Members 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 Member satisfaction.
- Medical record audits – Annual medical record review conducted by EQRO to evaluate the quality outcomes concerning timeliness of, and Member access to, Covered Services.
- Performance measures – Data on patient outcomes as defined by 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.

If the performance improvement projects, CAHPS, the performance measures, the annual medical record audit or the EQRO indicate that Humana's performance is not acceptable, then the Agency may impose penalties.

8.12 Community Outreach Provider Compliance

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

(a) Healthcare Providers may display Health Plan-specific materials in their own offices.

(b) Healthcare 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.

(c) Healthcare Providers may announce a new affiliation with a Health Plan and give their patients a list of Health Plans with which they contract.

(d) Healthcare 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 advertisement.

(e) Healthcare Providers shall not furnish lists of their Demonstration and ICP 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 enrollment.

(f) For the Health Plan, Providers may distribute information about non-Health Plan specific healthcare services and the provision of health, welfare and social services by the State of Illinois or local communities as long as any inquiries from prospective Members are referred to the Member services section of the Health Plan or the Agency's choice counselor/ enrollment broker.

8.13 Illinois Medicaid Provider Number

All Providers are required to have a unique Illinois Medicaid Provider number in accordance with the guidelines of the Agency. Providers are 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.

8.14 Provider Education of Compliance-based Materials

Providers are expected to adhere to all training programs identified as compliance-based training as identified by Humana. This includes agreement and assurance via a completed attestation that all affiliated Participating Providers and staff members are trained on the identified compliance material. This includes the following required, annual training modules:

- Humana Orientation
- Medicaid Provider Orientation
- Cultural Competency
- Health, Safety and Welfare Education
- Fraud, Waste and Abuse and General Compliance Training

Providers and Members of their office staff can access these online training modules* seven days a week, 24 hours a day at the following portal addresses:

Humana.com
Sign in to Humana.com/providers 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."

Availity.com
Sign in to www.availity.com with your existing user ID and password. If your organization is not yet registered, registration can be completed immediately (access is provided two to seven business days after registration).

Once signed in, navigate to the "Payer Resources" page, select "Humana" from the list of payers that display in a new window, locate the "Compliance" section and then choose "Humana Compliance Events."

Select "I Agree" to the notice that displays in a new window indicating that you are leaving Availity's website.

A security warning pop-up may display indicating you are navigating to https://sso2.archer.rsa.com. Choose "Yes" to proceed to Humana's Compliance Portal. Follow the on-screen instructions to review and accept the required training.

* Directions how to access the CMS-published training document for general compliance and fraud, waste and abuse training can be found on Humana.com/fraud

If you are unable to access the Internet, please call our Provider Relations department at 1-800-626-2741 for copies of printed materials.

For Long-term Care Services and Behavioral Health providers, please see Long-term Care Services and Behavioral Health sections below for contact information and help in understanding how to access this required training.

8.15 Requirements regarding community outreach activities and marketing prohibitions:

- In accordance with Mandates, Providers are not authorized to send referrals to State offi
- In accordance with 42 CFR 438.104(b)(1)(iv), Humana and its subcontractors shall not seek to infl enrollment in conjunction with the sale or offering of any private insurance.
- In accordance with 42 CFR 438.104 (b)(1)(v), Humana and its subcontractors shall not directly or indirectly, engage in door-to-door, telephone, or other cold-calling marketing activities.
- In accordance with 42 CFR 438.104 (b)(2)(i), Humana and its subcontractors shall not, directly make any assertion or statement (whether written or oral) that the benefi must enroll with Humana in order to obtain (Medicaid State Plan benefi or in order to not lose benefi (Medicaid State Plan benefi
- In accordance with 42 CFR 438.104 (b)(2)(ii), Humana and its subcontractors shall not make any inaccurate false or misleading claims that Humana is recommended or endorsed by any Federal, State or county government, the Agency, CMS, Department, or any other organization which has not certifi its endorsement in writing to Humana.

Additional Requirements for ICP Providers:

Unless Prior Approval is provided by the Department, Contractor shall not:

- Provide cash to Potential Members, Prospective Members or Members, except for reimbursement of expenses and stipends, in an amount approved by the Department, provided to Members for participation on committees or advisory groups;
- Provide gifts or incentives to Potential Members or Prospective Members unless such gifts or incentives: (i) are also provided to the general public; and, (ii) do not exceed ten dollars ($10) in value per individual gift or incentive;
- Provide gifts or incentives to Members unless such gifts or incentives (i) are provided conditionally based on the Member receiving preventive care or other health related activity; and, (ii) are not in the form of cash or an instrument that may be converted to cash;

8.16 Providers must notify Humana of Members' hospice status immediately upon discovery.

9. Medical Records Standards

For each MMAI Member, the Provider should maintain detailed and legible medical records that include the following:

(1) Member's identifying information including name, Member ID, date of birth, sex and legal guardianship (if any);

(2) A summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications;

(3) Description of chief complaint or purpose of visit, the objective diagnosis, medical findings of the impression of the Provider;

(4) Identification of any studies ordered and any referral reports;

(5) Identification of any therapies administered and prescribed;

(6) Name and profession of the Provider rendering services, including the signature or initials of the Provider;

(7) Disposition, recommendations, instructions to the Member, evidence of whether there was follow-up and outcome of services;

(8) Immunization history;

(9) Information relating to the Member's use of tobacco products and alcohol/substance use;

(10) Summaries of all emergency services and care and hospital discharges with appropriate follow-up;

(11) Documentation of referral services and Member's medical records;

(12) All services provided by Provider (family planning services, preventive services, etc.);

(13) Primary language spoken by the Member and any translation needs of Member;

(14) Identify Members needing communication assistance in the delivery of healthcare services; and

(15) Documentation that the Member was provided written information concerning the Member's rights regarding Advance Directives and whether or not the Member has executed an Advanced Directive.

10. Claims 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:

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

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

For claim payment inquiries or complaints, please contact Humana customer care at 1-800-626-2741 or your Network Management Consultant.

For information regarding electronic claim submission, contact your local Network Management Consultant or visit **Humana.com** or www.availity.com.

10.1 Timely Filing

Providers are required to timely file their claims/encounters for all services rendered to Demonstration and/or ICP Members. Timely filing is an essential component reflected in Humana's HEDIS reporting and can ultimately affect how a Health Plan and its Providers are measured in Member preventative care and screening compliance.

Humana will make payments to Providers (including the fiscal agent making payments to Personal Assistants under the HCBS waivers for Covered Services) on a timely basis consistent with the Claims Payment Procedure described at 42 U.S.C. § 1396a(a)(37)(A) and 215 ILCS 5/368a. Complaints or disputes concerning payments for the provision of services are subject to Humana's Provider Grievance process.

Humana will pay 90 percent (90%) of all Clean Claims from Providers for Covered Services within thirty (30) days following receipt. Humana will pay 99 percent (99%) of all Clean Claims from Providers for Covered Services within ninety (90) days following receipt. For purposes of a Member's admission to a nursing facility, a Clean Claim means that the admission is reflected on the patient's credit file that Humana receives from the State. Humana will not be considered to be in breach of this Section, and the State will not impose a monetary sanction for Humana's failure to meet the requirements of this Section, if such purported breach or failure occurs at a time when the State has not paid any of the required capitation to Humana for two (2) consecutive months.

For ICP: Timely Provider Payments

Humana will ensure that ninety percent (90%) of payment of Clean Claims from Providers who are in individual or group practice for Covered Services will be paid within thirty (30) days after the date of receipt of the claim. Humana will ensure that ninety-nine percent (99%) of Clean Claims from Providers for Covered Services will be paid within ninety (90) days after the date of receipt of the claim. Humana and its Providers may by mutual agreement, in writing, establish an alternative payment schedule provided that payment is no less timely than provided in this Section.

Humana shall not deny claims for services delivered by Providers solely based on the period between the date of service and the date of Clean Claim submission, unless that period exceeds three hundred sixty-five (365) calendar days.

11. Cultural Competency

Culture and Cultural Competence

"Culture" refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, values and institutions that unite a group of people. "Cultural Competence" is the capability of effectively interacting with people from different cultures.

Culture impacts the care that is given to patients. Culture informs:

- Concepts of health and healing
- How illness, disease, and their causes are perceived
- Behaviors of patients who are seeking healthcare
- Attitudes toward healthcare Providers

Culture impacts every healthcare encounter:

- Who provides treatment
- What is considered a health problem
- What type of treatment
- Where care is sought
- How symptoms are expressed
- How rights and protections are understood

Clear Communication

Limited English Proficiency (LEP) is the term that describes a Member who has an inability or a limited ability to speak, read, write, or understand the English language on a level that permits that individual to interact effectively with healthcare Providers or Health Plan Members.

Health Literacy

Health Literacy is the ability to obtain, process, and understand basic health information and services needed to make appropriate decisions. Over a third of patients have limited health literacy, which results in their not understanding what they need to take care of their health. Limited health literacy is associated with poor management of chronic diseases, poor ability to understand and adhere to medication regimens, increased hospitalizations, and poor health outcomes. Humana develops Member communications based on health literacy and plain language standards. The reading ease of Humana written Member materials is tested using the widely known Dale-Chall Readability tool.

Language Assistance Program (LAP) for Limited English Proficient (LEP) Members

Humana is committed to providing free language assistance services for its Members with LEP. This includes:

- Free interpretation services for all languages. Providers may call Humana at the phone number listed on the Member's Humana ID card to access interpretation services while the Member is in the office.
- Spanish versions of Humana's nonsecure website and Member materials
- TTY/TDD services
- Members are given the opportunity to request a written translation of Humana documentation mailed to them. Members should call the customer service phone number listed on the back of the Member's Humana ID card to request translated materials.

Cultural Competence – Subcultures and Populations

With growing concerns about health inequities and the need for healthcare systems to reach increasingly diverse patient populations, cultural competence has increasingly become a matter of national concern. There are also growing concerns about different health issues that are affecting the American society, which can differ among ethnic groups.

"Subculture" means an ethnic, regional, economic, or social group exhibiting characteristic patterns of behavior sufficient to distinguish it from others within an embracing culture or society. Understanding the many different subcultures that exist within our own culture is also an important aspect of cross-culture healthcare.

To be able to take care of the health issues in the different ethnicities which we have in this country, Providers need to be able to understand the values, beliefs, and customs of these different people. Some of the cultural aspects that may impact health behavior are:

- Eye Contact – Many cultures use deferred eye contact to show respect. Deferred eye contact does not mean that the patient is not listening to you.
- Personal Space – Different cultures have varying approaches to personal space and touching. Some cultures expect more warmth and hugging in greeting people.

- Respect for Authority – Many cultures are very hierarchical and view doctors with a lot of respect; therefore, these patients may feel uncomfortable questioning doctors' decisions or asking questions.

Cultural Competence – Seniors and People with Disabilities

Humana develops individualized care plans that take into account Members special and unique needs, including Members with disabilities in accordance with the Americans with Disabilities Act (ADA). People with disabilities must be consulted before an accommodation is offered or created on their behalf. Some considerations in treating seniors and people with disabilities are:

- Disease and multiple medications
- Caregiver burden/burnout
- Cognitive impairment and mental health
- Visual impairment
- Hearing impairment
- Physical impairment

12. Member Rights and Responsibilities

Provider must be aware of the Member Rights and Responsibilities prescribed by Illinois Law. These rights and responsibilities are listed below.

12.1 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 request home PCP visits if he/she is homebound or has significant mobility limitations.
7. A Member has the right to know what rules and regulations apply to his or her conduct.
8. A Member has privacy rights under the Health Insurance Portability and Accountability Act (HIPAA). This is a federal law that protects health information. These rights are important for you to know. Members can exercise these rights, ask questions about them, and file a Complaint if they think their rights are being denied or their health information is not being protected.
9. A Member has the right to be given by the healthcare Provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
10. A Member has the right to a second opinion by a qualified in-network Provider and if one is not available, an out-of-network Provider will be made available at no cost to the Member.
11. A Member has the right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, except as otherwise provided by law.

12. 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.

13. A Member who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare Provider or healthcare facility accepts the Medicare assignment rate.

14. A Member has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

15. 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.

16. 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.

17. A Member has the right to be furnished healthcare services in accordance with Federal and State regulations.

18. A Member has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

19. A Member has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

20. 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.

21. 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.

22. The State must ensure that each Member 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 Member.

23. A Member has the right to express Grievances regarding any violation of his or her rights, as stated in Illinois law, through the Grievance procedure of the healthcare Provider or healthcare facility which served him or her and to the appropriate State licensing agency.

12.2 Member Responsibilities

1. A Member is responsible for providing to the healthcare 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 healthcare Provider.

3. A Member is responsible for notifying his/her PCP of any significant mobility limitations or homebound status that will warrant the need for PCP home visits.

4. A Member is responsible for reporting to the healthcare Provider whether he or she understands a possible course of action and what is expected of him or her.

5. A Member is responsible for following the treatment plan recommended by the healthcare Provider.

6. A Member is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the healthcare Provider or healthcare facility.

7. A Member is responsible for his or her actions if he or she refuses treatment or does not follow the healthcare Provider's instructions.

8. A Member is responsible for assuring that the financial obligations of his or her healthcare are fulfilled as promptly as possible.

13. Fraud, Waste and Abuse

Both the federal government and the individual states that are establishing and monitoring requirements for Medicare and Medicaid are trying to reduce fraud, waste and abuse (FWA) in the Medicare and Medicaid programs. Healthcare FWA can involve physicians, pharmacists, Members, and even medical equipment companies. Success in combating healthcare fraud, waste, and abuse is measured not only by convictions, but also by effective deterrent efforts.

Anyone who suspects or detects a FWA violation is required to report it either to Humana or within his/her respective organization, which then must report it to Humana:

Telephonic:

- 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:

- www.ethicshelpline.com

Key Features of Methods for Direct Reporting to Humana:

Anonymity: If the person making the report chooses to remain anonymous, he/she is encouraged to provide enough information on the suspected violation (i.e. date(s) and person(s), system(s), and type(s) of information involved) to allow Humana to review the situation and respond appropriately.

Confidentiality: Processes are in place to maintain confidentiality of reports; Humana allows confidential report follow-up.

Humana strictly prohibits intimidation and/or retaliation against anyone who, in good faith, reports suspected or detected violation of ethical standards.

Additional information on this topic is included in the Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training document that is published by the Centers for Medicare & Medicaid Services (CMS). Note: The concepts in the CMS document apply to all Humana lines of business. Please refer to subsection 8.14 of Section I for more detailed information and directions regarding how to access this required, annual training.

14. Health, Safety and Welfare

When a Provider suspects there is a risk of abuse, neglect or exploitation, he/she is required by law to report it immediately to the appropriate State agency and the Humana Care Manager that is participating on the Member's Interdisciplinary Team (ICT). This includes, but is not limited to:

- Abuse – Nonaccidental 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 which 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.

In most states, individuals that report these situations receive immunity from civil and criminal liability unless the report was made in bad faith or with malicious intent, and identity protection unless a court orders the identity of the reporter be revealed.

Additional information on this topic is included in Humana's required Health, Safety and Welfare Education annual compliance training as identified by Humana. Please refer to the information in subsection 8.14 of Section I for more detailed information and directions regarding how to access this required training.

SECTION II – LONG-TERM CARE SERVICES

1. Introduction

Humana has partnered with Independent Living Systems (ILS) to manage the delivery of long-term care services for its Medicaid Medicare Alignment Initiative (MMAI) Demonstration and Integrated Care Plan (ICP) Members in Illinois. This document has been developed in order to familiarize Providers with Health Plan and Independent Living Systems of Illinois ("ILS"). The Health Plan, or ILS on behalf of Health Plan, issues a Provider Manual Appendix to you after your credentialing is complete. We may choose not to distribute the Appendix via surface mail, but rather give a written notification to you that explains how to obtain the handbook from a website. This notification would also detail how you can request a hard copy at no charge. The Appendix and bulletins are kept up to date and in compliance with State and Federal

laws. The Appendix shall serve as a source of information regarding Health Plan's Covered Services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all requirements of a Government Sponsored Contract are met.

1.1 Welcome

Welcome to your Health Plan and Independent Living Systems of Illinois, LLC's Network of Participating Providers. As a Long-term Services and Supports (LTSS) Professional, you play a very important role in the delivery of healthcare services to the Health Plan Members.

This Appendix is intended to be used as an orientation and guideline for the provision of covered services to Health Plan Members. This Appendix contains policies, procedures and general reference information including minimum standards of care which are required of Health Plan Providers.

As an ILS Network Provider, we hope this information will help you better understand the Health Plan and Independent Living Systems of Illinois, LLC. Should you or anyone on your staff have any questions about any information contained in this Appendix or anything else about ILS or the Health Plan Contractor, please feel free to contact the Health Plan representative or your ILS Provider Network Associate. We look forward to working with you and your staff to provide quality managed healthcare service to Health Plan Members.

The vision is to benefit all stakeholders by considering consumer choice and outcomes, Provider qualifications, and the Health Plan Contractor requirements.

1.2 Overview

- The Contractor (Health Plan) bears the underwriting risk of all services covered under contract.
- Services are to be provided in accordance with an individualized care plan developed by the Health Plan in consultation with the Member and which will include services determined through an assessment by the Health Plan to be necessary to address the health and service needs of the Member.
- The Health Plan may not require any copayment or cost sharing by Members except the patient responsibility amount for nursing facility or Supportive Living Facility services or any copayments established under State law for Members of the Demonstration, the ICP or the State's Medicaid Program.
- The Health Plan does not permit Members to be charged for missed appointments.
- Typically, the Health Plan is financially responsible for Medicare coinsurance and deductibles for covered services. The Health Plan would then reimburse Providers for Medicare deductibles and coinsurance according to Medicaid Guidelines or the rates negotiated by the Health Plan with the Provider.
- All services delivered by the Health Plan contractor to Members, either directly or through a subcontract, must be guided by the following service delivery principles:

  1. Services must be individualized as a result of a competent, comprehensive understanding of a Member's multiple needs.
  2. Services must be delivered in a timely fashion in the least restrictive, cost-effective and appropriate setting.
  3. Long-term Services and Supports (LTSS) must be based upon a Member's plan of care and include goals, objectives, and specific treatment strategies.

4. Services must be coordinated to address comprehensive needs and provide continuity of care.

5. Services must be delivered regardless of geographic location within the service area, level of functioning, cultural heritage, and degree of illness of the Member.

6. The project's administration and service delivery system must ensure the participation of the Member in care planning and delivery, and, as appropriate, allow for the participation of the family, significant others, and caregivers.

7. The contractor shall provide interpreter services in person where practical, but otherwise by telephone, for applicants or Members whose primary language is foreign. Foreign language versions of materials are required if, as provided annually by the agency, the population speaking a particular foreign (non-English) language in a county is greater than fi e (5) percent.

8. Services must be delivered by qualified Providers as defined by applicable contract. The Contractor has a credentialing system that includes procedures for credentialing LTSS Providers.

9. All facilities providing services to Members must be accessible to persons with disabilities, be smoke free, and have adequate space, supplies, good sanitation, and fire and safety procedures.

Managed care has become an important part of care coordination and integration of services for the enrolled Members. The State contracts with a qualified Contractor/Health Plan for a program offering various features to the Medicaid consumer who is "at risk" of placement in a nursing home or otherwise meets a Medicaid program qualification. This Contractor will use LTSS Providers, such as Supportive Living Facilities, Adult Day Care, Skilled Nursing Facilities, Home Health, and Personal Care Organizations in their network.

The Provider Relations Department is responsible for Provider education, recruitment, contracting, and new Provider orientation. The Quality Management Department in coordination with the Credentialing Department is responsible for monitoring of quality and regulatory standards, and investigation of Member Complaints and Grievances. The Credentialing Department presides over the credentialing and recredentialing process and coordinating contract loads, demographic changes, and Provider terminations in the Provider Data Management system.

The Provider Relations Department offers our network partners an array of Provider services that includes initial orientation and education for all Providers. These sessions are hosted by Provider relations representatives and available in person, group settings and webinars.

2. Provider Definition and Status

An eligible "Provider" of Covered Services is identified in the State Demonstration or ICP and Contract. Only Licensed Providers are eligible to provide services to Plan Members. The Health Plan will work with the Credentialing Guidelines and Policies designed with the welfare and well-being of the Member in mind.

The guidelines are designed to assist the Health Plan in determining acceptance of facilities and other Providers as participants in their network. In addition, the guidelines will help ensure consistency, accuracy and timeliness of credentialing across all Health Plan sites and provide a tool to perform the facility credentialing.

Further, during a statewide or national emergency, healthcare organizations wish to do whatever it takes to provide critical services to citizens in need. Therefore,

- Any Licensed LTSS Provider may be authorized to provide voluntary services during an emergency, regardless of whether they have previously been contracted.

- The Health Plan's chief executive officer or his/her designee could be authorized to grant temporary emergency privileges during a national or state emergency.
- To verify license status of a LTSS Provider, online resources or a copy of the license may be used.

2.1 Provider Contracting, Application, and Credentialing

The LTSS Provider has the responsibility of providing the necessary items for contracting.

All Participating Providers must be credentialed prior to their contract effective date with the Contractor and usually re-credentialed every three years. The Contractor's Credentialing Committee is required to recommend approval or denial of all Providers into the network. Provider contracting and credentialing policy is available through the Provider Relations representative.

General Provider Credentialing Requirements for the Health Plan Contractor

The minimum requirements include, but are not limited to, the following:

- Current, applicable and required State license(s) verified;
- Absence of a history of sanctions or other actions warranting denial of participation status.
- Absence of exclusion or debarment from participation in Medicare, Medicaid or other State or Federal healthcare programs including the Office of the Inspector General (OIG) and General Services Administration (GSA) warranting denial of participation status.
- Completion of a criminal history background check to determine whether Subcontractor has any history of felony convictions, including adjudication withheld on a felony, plea of nolo contendere to a felony, or entry into a pretrial agreement for a felony.
  - A letter of compliance with background screening may be required as part of the credentialing monitoring process of ILS and the Health Plan.
- Additional requirements may be involved depending on the Health Plan and program involved.
- The Provider warrants in contract that they comply with State laws related to liability and workers compensation.
- Certification, accreditation, or threshold criteria may also apply.

2.2 Time Periods to Note

- Applications must be completed within 180 days of Provider signature.
- If Letter of Agreement used, it will have an expiration date and need to be replaced by full application and agreement.
- Re-credentialing will occur every three years.
- Out-of-network or other authorizations are limited to the terms of the authorization.

3. Provider Policies and Responsibilities

3.1 Equal Provider Opportunity

ILS and the Health Plan are equal opportunity organizations. Provider participation decisions are nondiscriminatory and are based on merit and business needs, and not on race, color, citizenship status, national origin, ancestry, gender, sexual orientation, age, weight, religion, creed, physical or mental disability, marital status, veteran status, political affi or any other factor protected by law.

3.2 Affirmative Action, Diversity and the Cultural Competency Plan

We are committed to embracing diversity in the provision of services to Members and in providing fair and equal opportunities for all qualified minority businesses. The Contractor tracks and reports information to applicable agencies on utilization of certified and noncertified minority contractors and vendors for all Subcontractors and vendors receiving funds pursuant to all contracts covered. The Health Plan wishes to accommodate religious and cultural preferences of the Members and will seek input from the Provider that might be useful in meeting Member preferences.

The underrepresented Minority Recruitment Plan seeks to hire underrepresented Minority Health vendors when feasible and equitable. You may get a full copy of the Cultural Competency Plan, at no cost to the Provider, by writing IllinoisProviders@ilshealth.com.

3.3 Americans with Disabilities Act

It is the policy of ILS and the Health Plan to comply with all the relevant and applicable provisions of the Americans with Disabilities Act (ADA). We will not discriminate against any qualified Provider or job applicant with respect to any terms, privileges, or conditions of Provider because of a person's disabilities.

3.4 Contract, Law and License Compliance

The application of each Provider is contingent on verification of the candidate's right to provide services. Every Provider will be asked to provide documents verifying compliance.

3.5 Provider Background Check

BACKGROUND SCREENING RULES MAY CHANGE. REFER TO THE DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES WEBSITE FOR MOST CURRENT INFORMATION ABOUT YOUR LICENSE.

A background check may be applicable depending on the service and Provider type. A comprehensive background check may include prior Provider verification, professional reference checks, education confirmation, and OIG.

3.5.1 Criminal Record Check and Criminal Allegations

Most Provider licenses require a criminal record check be performed prior to issue of license. ILS and the Health Plan will not duplicate such effort if possible, but reserves the right to request a criminal record check to protect our interest and that of our clients and Members.

Any report that implies criminal intent on the part of Provider and is referred to a governmental or investigatory agency must be sent to the State Medicaid Agency. The Health Plan will investigate allegations regarding falsification of client information, service records, payment requests, and other related information. If the Health Plan has reason to suspect the allegations have basis, they will be referred as required by Mandates.

3.6 HIPAA Standards

The task of handling Member records and related administration functions is accomplished in strict compliance with the Health Insurance Portability and Accountability Act (HIPAA). Member files will be kept confidential at all times and includes some or all of the following precautions:

- Only request and work with Protected Health Information (PHI) related to "treatment, payment, or healthcare operations."
- Email should not be used to transfer files with Member info unless it is encrypted.
- Fax machines should be positioned for privacy.
- Fax numbers should be confirmed before sending info to ILS or the Health Plan.
- Leave minimum data on voice mail.

3.7 Change of Provider Data

Any change in a Provider's name, address, telephone number, or change of ownership, needs to be reported promptly in writing without delay to ILS Provider Relations at IllinoisProviders@ilshealth.com.

3.8 Provider Education of Compliance-based Materials

Providers are expected to adhere to all training programs identified as compliance-based training as identified by Humana and ILS. This includes agreement and assurance that all affiliated Participating Providers and staff members are trained on the identified compliance material. This includes the following training modules:

- Provider Orientation
- Medicaid Provider Orientation
- Cultural Competency (required annually)
- Health, Safety and Welfare Education (required annually)
- Fraud, Waste and Abuse Detection, Correction and Prevention (required annually)

For information on Humana's Cultural Competency Plan, see Section I – General Provider Information, subsection 12 above.

For information on Humana's Health, Safety, and Welfare Training, see Section I – General Provider Information, subsection 15 above.

For information on Humana's Fraud, Waste and Abuse Training, see Section I – General Provider Information, subsection 14 above.

Additional information on these topics is included in Humana's required annual compliance training as identified by Humana and ILS. Please contact ILS Provider Relations at 1-855-661-2029 for help in understanding how to access this required training.

3.9 Emergency service responsibilities

The Health Plan has an emergency management plan that specifies what actions the Health Plan shall conduct to ensure the ongoing provision of Covered Services in a disaster or man-made emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies. The Health Plan offers an after regular business hours Provider services line (not the prior authorization line) that is answered by an automated system with the capability to provide callers with information about operating hours and instructions about how to verify enrollment for a Member with an emergency or urgent medical condition. This shall not be construed to mean that the Provider must obtain verification before providing emergency services and care.

3.9.1 Weather-related and Emergency-related Closings

At times, emergencies such as severe weather, fires, or power failures can disrupt operations. In such instances, it is important that the Health Plan and ILS be kept informed of your status. This is of real significance if you have an active authorization for a Member. Resources man be found at the Illinois Emergency Management Agency website: www.state.il.us/iema.

4. Quality Improvement

4.1 Quality Improvement ("QI") Program Overview

Quality is not a delegated function by the Managed Care Organization. ILS has implemented a Quality Improvement and Performance Management Program (QI Program) designed to objectively monitor and evaluate the quality, appropriateness, and accessibility of healthcare and support services. The QI Program addresses the quality of clinical care throughout the continuum and focuses on key areas that include, but are not limited to:

- Coordination and continuity of care with seamless transitions across healthcare settings/services;
- Cultural competency and linguistic needs;
- Credentialing and recredentialing;
- Member safety;
- Confidentiality;
- Service utilization;
- Complaints;
- Adverse outcomes;
- Network adequacy;
- Provider satisfaction;
- Components of operational service; and
- Regulatory/Federal/State/accreditation requirements.

The goals of the QI Program are to:

- Develop and maintain a well-integrated system that continuously measures clinical performance and monitors key outcomes;
- Ensure availability and access to qualified and competent Providers;
- Establish and maintain safeguards for Member privacy, including confidentiality and Member health information;
- Ensure compliance and standards as required by contract, regulatory statues and accreditation agencies.

4.2 Provider Participation in the QI Program

Network Providers are contractually required to cooperate with quality improvement activities. Providers are invited to volunteer for participation in the QI Program through committee representation, quality/performance improvement projects, Grievances, and providing feedback/ input via satisfaction surveys.

4.3 The ILS Focus™ Process

The ILS Focus™ process seeks to identify low performing Providers at risk of being "Chronic Poor Performers." As part of a corrective action plan, a Participating Provider designated a "Chronic Poor Performer" will not be eligible to continue as a contracted Provider with the ILS Community Network, a Health Plan, or in a certain program. In the ILS Focus™ process the Provider will have the opportunity to improve performance or will be terminated as a Chronic Poor Performer. The mandated elements of any Corrective Action Plan will be reviewed by the Quality Committee and will be monitored by the Credentialing Committee. The Plan will be share in the designation of any elements included in a Corrective Action Plan.

A Credentialing Committee will review twice a year the progress of Providers that may be identified in the low performing category. Identification of low performers may come from State, Federal, or MCO information drawing from surveys, Complaints and performance measures.

Elements that would be indicative of a low performer may come from the following:

Elements that could indicate any Provider as being a Chronic Poor Performer include, but are not limited to:

- Notification by a Care Coordinator of adverse incidents, significant changes in a Member's health status.
- Have sufficient staff as specified in Mandates.
- Compliance with services as contracted and authorized including timeliness of service.
- Delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.
- Percentage of Members with Care Plan in file.
- Percentage of Members with Living Will in file.
- Percentage of Members with DNR instructions in file.
- Percentage of staff with background screening attestation on file.
- Complaints.

5. Standards of Conduct

5.1 Stakeholder Expectations

The LTSS Provider is a problem solver and resource for the Member. The LTSS Provider contributes to positive outcomes by reference to a care plan and collaboration regarding self-management and wellness issues for the resident.

Stakeholders will include the LTSS Provider, the Health Plan/Contractor, Resident/Member and their Sponsors, State and Federal Agencies and third-party healthcare Providers. Contractor is a resource for the LTSS Provider in meeting Stakeholder Expectations.

One of the benefits of the Health Plan is the professional Case Management team that develops a Care Plan for the Member and will make appropriate information in that Care Plan available for the LTSS Provider use.

Your ILS agreement specifies in Sections related to Quality Assurance; Record Keeping; Policies and Procedures; Provider Responsibilities Attachments; and appropriate scheduling guidelines for service delivery. Those sections referenced and the entire ILS Agreement is relevant and included by reference to the Provider Handbook. Please be sure to review.

The Health Plan has also developed a process for monitoring the scheduling of service delivery and the actual time Members must wait to receive the service. When the service delivery scheduling or waiting times are excessive, the Health Plan must take appropriate action to ensure adequate service delivery. Each Health Plan contract will communicate their specific processes during orientation by ILS and/or Health Plan as applicable and appropriate for the Covered Services you will provide.

5.2 Reporting Significant Member Health Outcomes

Facility and Home Health Providers will provide notice to the Health Plan within 24 hours upon an Adverse Event: A Member dies, leaves the facility against medical advice, or Neglect, Abuse, Exploitation and Fraud, which should be reported to regulatory authorities.

LTSS Provider will also report Member changes in Health Outcomes to the Health Plan Case Manager. Such adverse events would include the following:

- Decline in Member's health status due to management of medications
- Significant worsening of ADLs
- Two or more behavioral health conditions
- Significant change in toileting ability
- Falls or accidents (with or without injury)
- All Adverse Health Outcomes reporting and reviews are part of the quality initiatives

5.3 Incident Reporting

Provider agrees to implement a systematic process for incident reporting and to notify ILS immediately and no later than 24 hours of occurrence, of an incident that may jeopardize the health, safety and welfare of a Member or impair continued service delivery. Reportable conditions include, but are not limited to:

(1) Closure of Provider services or facilities due to license violations;

(2) Provider financial concerns/difficulties;

(3) Loss or destruction of Member records;

(4) Compromise of data integrity;

(5) Fire or natural disasters; and

(6) Critical issues or adverse incidents that affect the health, safety, and welfare of Members.

In the incident log, Provider shall contain a brief summary of the problem(s) and proposed corrective action plans and time frames for implementation within a reasonable time after the incident is reported. Provider shall submit the incident log to ILS or the Health Plan within 30 days of the occurrence date with process and password protection for HIPAA-related information.

The Provider must ensure that each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Provider and its employees or affiliates treat the Member.

Compliance with other Federal and State laws. The Provider will comply with any other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality).

5.4 Member Transition to Another Network Provider

The Health Plan will help Members transition to another Provider if their Provider leaves the Health Plan's network. This policy is addressed in the Care Coordination Policies and Procedures.

The Health Plan will transition Members to new Providers, if needed, during the transition period and once the transition period is over. This policy is addressed in the Care Coordination Policies and Procedures.

On Feb. 22, 2013, the Illinois Department of Healthcare and Family Services (HFS) received approval from CMS to jointly implement the Medicare-Medicaid Alignment Initiative (MMAI) (Demonstration). The Demonstration is a groundbreaking joint effort to reform the way care is delivered to clients eligible for both Medicare and Medicaid Services (called "Dual Eligible Recipients"). The Demonstration project will provide coordinated care to more than 135,000 Medicare-Medicaid Members in the Chicagoland area and throughout central Illinois.

You can view more information on the Contract on the Centers for Medicare & Medicaid Services website.

- MMAI Provider Network Contact Information
- MMAI Contact Information
- MMAI Award Announcement
- MMAI Bidders (pdf)
- Rx Frequently Asked Questions (pdf)
- Detailed Drug Guidance (pdf)
- OTC Notice (pdf)
- MMAI RFP Questions and Answers 2nd Set of Questions (pdf)
- MMAI RFP OTC/Pharmacy Specific Questions and Answers (pdf)
- MMAI RFP Questions and Answers (pdf)
- MMAI HCBS Waiver Services Chart (pdf)
- Information on Medicaid-covered over-the-counter (OTC) drugs and products that are excluded from Medicare
- Central Illinois Area Medicare-Medicaid Alignment Initiative/2013-24-003 (pdf)
- Greater Chicago Area Medicare-Medicaid Alignment Initiative/2013-24-004 (pdf)
- Guidance for Offering Capitated Financial Alignment Demonstration Plans (pdf)
- Data Request Procedures for the Medicare-Medicaid Alignment Initiative (pdf)
- Required Data Use Agreement for Medicare-Medicaid Alignment Initiative Data (pdf)
- Data Dictionary (Providers Only) (xls)
- Frequently Asked Questions on Current Provider-Level Data (pdf)

6. Medicare-Medicaid Alignment Initiative Demonstration

6.1 Covered Services

- MMAI HCBS Waiver Services Chart (pdf)

6.2 Medical Necessity Standards and Practice Protocols

Medically Necessary or Medical Necessity — Services that include medical allied, or long-term care, goods or services furnished or ordered to:

1. Meet the guidelines pertaining to the treatment of chronic and complex conditions including:

   a. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;

   b. 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;

   c. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational;

   d. 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

   e. Be furnished in a manner not primarily intended for the convenience of the Member, the Member's caretaker or the Provider.

2. For those services furnished in a hospital on an inpatient basis, Medical Necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

3. The fact that a Provider has prescribed, recommended or approved medical, allied, or long-term care goods or services does not, in itself, make such care, goods or services medically necessary, a Medical Necessity, or a covered service/benefit.

4. The Health Plan will have protocols, policies, and procedures for individual Medical Necessity determinations (e.g., coverage rules, practice guidelines, payment policies). Some of those may be incorporated herein and some will be by identified in a Bulletin from the Health Plan. Guidelines pertaining to the treatment of chronic and complex conditions will be included in Health Plan Bulletins.

6.3 Health Plan Implements MMAI Demonstration Enrollment and Care Plans

- The Health Plan and State staff will identify current and/or new Members for the Contractor Plan.
- The Health Plan Care Coordinator will perform an assessment, with input from the LTSS Provider, on each new Member to determine the needed individual services and supplies and review the current plan of care.
- Once the needed services/supplies have been identified, the Health Plan Care Coordinator and the LTSS Provider Care Coordinator will finalize the care plan.

- Once the assessment and the care plan are completed, the Health Plan Care Coordinator and the LTSS Provider may complete a type of Care Plan Conference – Agreed Services Form or review copy of Service Plan that would identify each individual Member's assessment/care plan needs.

In Summary

- Care Coordinator will do assessment with Provider and Member input.
- Care Coordinator, Member, and Provider will agree on Service Plan.
- Interim report for events.
  - This is sent via fax to Health Plan Care Coordinator at the time of the event.
- LTSS Provider will also report Member Adverse Events to the Health Plan's Care Coordinator and assist Health Plan with review.

In accordance with ILS Policy, it is the responsibility of the Provider to submit all items necessary for claims processing.

7. Claims Submission Protocols and Standards

7.1 Provider Billing for Services

Network Providers shall provide services and supplies and receive payment in accordance with the contractual agreement with the Managed Care Plan.

7.2 Instructions and All Information Required for a Clean or Complete Claim:

The Provider shall submit a monthly claim to Managed Care Plan or ILS as applicable using the UB-04 billing form as applicable to program and Provider. Provider will be oriented and trained as to what process is applicable to their respective Provider Type.

7.3 Provider Billing

ILS, as Third-party Administrator (TPA), uses the Trizetto QNXT® system to process and adjudicate claims. We accept both electronic and paper claims submissions, but to assist us in processing and paying claims efficiently, accurately, and in a timely manner, we strongly encourage providers to submit claims electronically and support the process contractually. For example, electronic claim submissions are immediately processed through pre-import edits to evaluate the validity of the data, HIPAA compliance and Member enrollment information. They are uploaded into QNXT each business day. Within 24 hours of file receipt, ILS provides production reports and control totals to validate successful transactions and identify errors for correction and resubmission.

7.4 Examples of Acceptable Paper Claims Forms

ILS requires Providers to use one of the following forms when submitting paper claims:

- A CMS-1500 billing form is used to submit paper claims for professional services.

- Home healthcare, ICF, skilled nursing, and nursing home room and board must be billed on the UB-04 billing form. Home Healthcare is billed on the 1500 for ILS. The claims on the UB-04 for ILS are nursing home room and board and hospice room and board when member is in an LTC.

Completing a CMS-1500

The CMS 1500 billing form is used to submit paper claims for professional services. Before submitting a claim, a Provider should ascertain that all required attachments are included. All claims that involve other insurance must be accompanied by an Explanation of Benefits (EOB) or a Remittance Advice (RA) that clearly states how the claim was paid or the reason for denial.

Completing the UB-04

The UB-04 form is used when billing for facilities services, including nursing home room and board and ICF services.

7.5 Claims Submission

Electronic Claims Submission

To submit electronic claims, Providers will need to obtain the required software for electronic claim submission to Emdeon®. The first step is to register with Emdeon or another Clearinghouse. Once registered, providers will be able to submit electronic claims following instructions from the clearinghouse.

- Providers will need to use the ILS payer ID of 45048 when billing through the clearinghouse.
- Providers can submit hard copy claims directly to ILS via U.S. mail at:

ILS
P.O. Box 5787
Hauppauge, NY 11788

7.6 Clean Claim Submission

ILS can only process Clean Claim submissions; unclean claims will not be processed and will be returned to the provider for correction. A "Clean Claim" is considered as one that can be processed (adjudicated) without obtaining additional information from the service Provider or from a third party. It does not include claims submitted by Providers under investigation for fraud or abuse or those claims under review for Medical Necessity.

The Health Plan shall reimburse Providers for the delivery of authorized Covered Services as described in the Mandates and the Member's benefit Plan. The Provider must mail or electronically transfer (submit) the claim to the Health Plan within six (6) months of the date of service or discharge from an inpatient setting; or the date that the Provider was furnished with the correct name and address of the Health Plan.

When the Health Plan is the secondary payer, the Provider must submit the claim to the Health Plan within ninety (90) calendar days after the final determination of the primary payer, and in accordance with the Medicaid Provider General Handbook.

7.7 Claims Payment Time Frames

ILS processes clean claims according to the following time frames: For electronic submissions, ILS will provide an electronic acknowledgment of the receipt of the claim within twenty-four (24) hours after the beginning of the next business day after receipt of the claim.

For paper claims, will provide acknowledgment of receipt of the claim within fifteen (15) calendar days after receipt of the claim, to the Provider or designee or provide the Provider or designee with electronic access to the status of a submitted claim.

- Pay or deny 95% of the clean claims within 30 days of receipt
- Pay or deny 99% of clean paper claims within 90 days of receipt

If applicable, Providers paid on a capitation basis will be paid according to the time period specified in your Provider Agreement with ILS. Claims not billed within the required time frame will be considered waived.

7.8 Claims Resubmission

For Network Providers

- We will consider a claim for resubmission only if it is rebilled in its entirety within 365 days from date of service. Provider must include a letter outlining the reason for submission.

For Non-Network or Non-Par Providers

- We will consider a claim resubmission within 365 days from the primary payers' Remittance Advice EOB.

7.9 Claims Reconsideration

Providers have 365 days from the date of remittance to resubmit a claim or the original payment will be considered full and final for the related claims. Providers must include the nature of the request, Member's name, date of birth, Member identification number, service/admission date, location of treatment, service or procedure, documentation supporting request, copy of claim, and a copy of remittance advice on which the claim was denied or incorrectly paid. Providers must additionally address the following labels on the claim when submitting a claim for reconsideration:

ATTN: Claims Dept – Reconsideration Claim

Independent Living Systems
10000 NW 25th St.
Miami, FL 33012

Medicare and Other Primary Payer Sources

Eligible Health Plan Members can access services that are covered by Medicare through fee-for-service Medicare or a Medicare Advantage product. In the MMAI Demonstration, the Health Plan is the payer of last resort for Medicaid-covered services. As applicable, Providers must bill any other third party insurance before submitting a claim to ILS. We will pay the difference between the primary insurance payment and the Health Plan allowable amount. If the payment from the primary payer is greater than or equal to the amount allowable under the terms of the Provider agreement with ILS/the Health Plan, ILS and the Health Plan have no further obligation for payment. Providers cannot balance bill Members.

If the primary insurance carrier denies the claim as a Noncovered Service, the claim with the denial may be submitted to ILS for a coverage determination.

It is the Provider's responsibility to obtain the primary insurance carrier's explanation of benefits (EOB) or the Remittance Advice for services rendered to members that have insurance in addition to the Health Plan. The primary carrier's EOB or Remittance Advice should accompany any claims submitted for payment. A detailed explanation of how the claim was paid or denied should be included if not evident from the primary carrier's EOB or the Remittance Advice. This information is essential in order for the Health Plan to coordinate benefits.

If a service is a Noncovered Service or benefi have been exhausted from the primary carrier, the Provider is required to get an updated letter from the primary carrier every January and July to submit with each claim. Claims submitted without the EOB for Members where third party insurance is available will be denied in most cases. Providers have a maximum of 365 days from the date of the EOB to complete Coordination of Benefi

To prevent denials for coding mismatches, claims submitted to the primary carrier on a form that differs from ILS requirements should be clearly marked with "COB Form Type Conversion."

Overpayment/Underpayment

ILS provides 30 days written notice to healthcare Providers before engaging in overpayment recovery efforts, allowing the healthcare Provider the opportunity to challenge the recovery, unless the recovery is for duplicate payment. In the event that a Provider identifies any overpayments, it is the Provider's responsibility under Section 6402(a) of the Patient Protection and Affordable Care Act to report and refund the overpayment within sixty (60) days following its initial identification. In addition, the Provider must provide ILS with a written reason for the overpayment (e.g., excess payment under coordination of benefits, etc.).

7.10 Claims Inquiries

Providers can check the status of claims by contacting the Claims Department at 1-855-430-3616.

7.11 Provider Claims Disputes

Providers can submit claims disputes directly to ILS via mail at:

ATTN: Claims Department
Independent Living Systems
10000 NW 25th St.
Miami, FL 33012

The Provider must include the following information/items:

- A completed Provider Dispute Form (available on our website)
- Nature of the request (legal and factual basis for dispute)
- Member's name, date of birth, and Member identification number
- Service/admission date
- Location of treatment, service, or procedure
- Clinical information and/or records/documentation supporting request
- Copy of Remittance Advice on which the claim was denied or incorrectly paid

ILS has a procedure to resolve claim disputes. This process is described in Chapter 7 of this Appendix section regarding Appeal, Grievance, and Fair Hearings.

7.12 Prior Authorization and Referral Procedures, Including Required Forms

Service planning must involve the Member and/or Member representative working cooperatively with the Member's Care Coordinator. Service authorizations must reflect services specified in the plan of care. When service needs are identified, the Member must be given information about available providers, so that an informed choice of providers can be made.

7.13 Protocols for Submitting Encounter Data

The Health Plan is authorized to take whatever steps are necessary to ensure that the Provider is recognized by the State Medicaid program, including its enrollment broker contractor(s) as a participating Provider of the Health Plan and that the Provider's submission of encounter data is accepted by the State's MMIS and/or the State's encounter data warehouse. If you currently do not have a Medicaid ID the Plan will work to get a Medicaid ID assigned that could be used to track encounter data through the Plan.

Claims Department email is claimsdept@ilshealth.com. Mailing address for claims is:
ILS
P.O. Box 5787
Hauppauge, NY 11788

7.14 Medical/Case Records Standards

Standards shall support a clean claim, encounter data, Program Integrity (fraud) requirements, Quality enhancement, HIPAA standards, and Medical necessity. The Member case record includes Member specific documents and documentation of all activities, interactions and contacts with the Member, their representative, their Case Manager and any other provider(s) involved in the support and care of the Member. The Case Management Member file information is maintained by the Plan in compliance with the State and Federal regulations for record retention. The plan manages this process through an approved policy and procedure and is available upon request.

8. Complaints

You may call the Provider Call Center to report your Complaint. The number is 1-855-661-2029.

These tools and information are available from your Provider Relations representative.

9. Tools & Information of Value

9.1 NPI – National Provider Identifier Standard

The Health Plan shall require each Provider to have a National Provider Identifier (NPI) in accordance with s. 1173(b) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997. The Provider contract requires Providers to submit all NPIs to the Health Plan. The Health Plan files the Providers' NPIs as part of its Provider network file to the State Medicaid Agency or its agent. The Health Plan need not obtain an NPI from an entity that does not meet the definition of "healthcare Provider" found at 45 CFR 160.103:

(1) Individuals or organizations that furnish atypical or nontraditional services that are only indirectly related to the provision of healthcare (examples include taxis, home modifications, home delivered meals and homemaker services); and

(2) Individuals or businesses that only bill or receive payment for, but do not furnish, healthcare services or supplies (examples include billing services and repricers).

Healthcare Providers can apply for NPIs in one of three ways:

- For the most efficient application processing and the fastest receipt of NPIs, use the Web-based application process. Simply sign in to the National Plan and Provider Enumeration System (NPPES) and apply online (see related links inside CMS).
- Healthcare Providers can agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so.
- Healthcare Providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, North Dakota, whereby staff at the NPI Enumerator will enter the application data into NPPES. The form will be available only upon request through the NPI Enumerator. Healthcare Providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of these ways:

Phone: 1-800-465-3203 or TTY 1-800-692-2326; email: customerservice@npienumerator.com; Mail: NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059. Share NPI with ILS by emailing to claims@ilshealth.com or fax to 1-800-963-0352. As required by the CFR (Code of Federal Regulations), Provider shall submit all National Provider Identifiers (NPIs) to Plan c/o ILS within 15 business days of receipt.

9.2 Credentialing

To participate in Humana's network, Providers must be credentialed. Recredentialing occurs every three years. LTSS providers must, at a minimum, meet all regulatory guidelines.

9.3 Attestations Adopted by and Applicable to Providers

The Provider acknowledges and attests he or she will maintain compliance in that all direct service Providers who may be required by State Mandates to attend and complete an Abuse, Neglect & Exploitation Training. It is the Provider's responsibility to use Abuse, Neglect and Exploitation training materials that have been approved, in advance, per any Mandates, and to maintain necessary documentation of this training for the employees that have contact with the Health Plan Members and make this documentation available to ILS, the Health Plan, and the applicable State Agency, as requested.

9.4 Home and Community-based Services (HCBS) in Supportive Living Facilities

The OIG published this report in December 2012 – HOME AND COMMUNITY-BASED SERVICES IN ASSISTED LIVING FACILITIES, OEI-09-08-00360. OIG recommend that CMS issue guidance to State Medicaid programs emphasizing the need to comply with Federal requirements for covering HCBS under the 1915(c) waiver. CMS has also published expectations regarding person-centered plans of care and to provide characteristics of settings that are not home and community-based to ensure State compliance with the statutory provisions of section 1915(c) of the Act.

What this means for Residential HCBS Providers such as Supportive Living Facilities (SLF) is summarized as follows:

- A focus on quality of services provided
- An Individualized Person-Centered Care Plan
- A community integration goal planning process
- The right to receive home and community-based services in a home-like environment

As a result, the Health Plan may take interventions or remediation steps that the State would expect to see. The following are some examples of such interventions or remediation steps an MCO may implement upon discovery that an SLF is not maintaining a home-like environment:

- The MCO will work with the SLF administrators and staff to correct the identified deficiencies within a time frame mandated by the State.
- MCO will not refer Members to the noncompliant SLF until outstanding deficiencies are resolved.
- The MCO will terminate from its network SLFs that consistently fail to exhibit home-like characteristics and that do not resolve outstanding issues.
- As a last resort, the MCO may counsel a Member who is not residing in a home-like environment that he/she will not be able to continue to receive HCBS waiver services in a noncompliant facility. If the individual wishes to remain in the SLF, he/she may face disenrollment.
- If the Health Plan terminates a contract with an SLF, and the Member agrees to move to a different SLF, the Health Plan would facilitate transferring the Member to an SLF that meets the home-like environment requirements.

Residential Facility Providers agree to comply with the home-like environment and community integration language provided by the State. Such language may be included in your Provider agreement. All Providers must also comply with the applicable Resident Bill of Rights and attest to being in compliance as part of the monitoring and/or credentialing process.

SECTION III – BEHAVIORAL HEALTH

1. Program Description

1.1 Beacon/Humana Partnership

Humana has partnered with Beacon Health Options, LLC (Beacon) to manage the delivery of behavioral health services for its Medicaid Medicare Alignment Initiative (MMAI) Demonstration and Integrated Care Plan (ICP) Members in Illinois. The Demonstration is designed to provide Members who are dually eligible for both Medicare and Medicaid with high quality, integrated care. Members enrolled in the Demonstration and ICP programs are eligible to receive comprehensive assessments, care planning and coordination from Humana. For further details, please refer to the Humana section of this Provider Manual Appendix.

Beacon is a limited liability, managed behavioral healthcare company. Established in 1996, Beacon's mission is to collaborate with our Health Plan Members and network Providers to improve the delivery of behavioral healthcare for the Members we serve.

Beacon provides behavioral health management services to 42 million people, through partnerships with over 50 Health Plan partners in 50 states. Most often co-located at the physical location of our Health Plan partners, Beacon's "in-sourced" approach deploys utilization managers, care managers and Provider network professionals into each local market where Beacon conducts business. This approach facilitates better coordination of care for Members with physical, behavioral and social conditions and is designed to support a "medical home" model. Quantifiable results prove that this approach improves the lives of individuals and their families and helps Health Plans to better integrate behavioral health with medical health.

1.2 Beacon/Humana Behavioral Health Program

The Humana behavioral health program provides Members with access to a full continuum of behavioral health services through our network of Beacon Network Providers. The primary goal of the program is to provide Medically Necessary care in the most clinically appropriate and cost-effective therapeutic settings. By ensuring that all Health Plan Members receive timely access to clinically appropriate behavioral healthcare services, Humana and Beacon believe that quality clinical services can achieve improved outcomes for our Members.

1.3 Network Operations

Beacon's Network Operations Department, with Provider Relations, is responsible for the procurement and administrative management of Beacon's behavioral health Provider network. Beacon's role includes contracting, credentialing and Provider relations functions for all behavioral health contracts. Representatives are easily reached by email at provider.relations@beaconhs.com, or by phone between 8:30 a.m. – 6 p.m. Eastern time, Monday – Thursday, and 8:30 a.m. – 5 p.m. Eastern time on Fridays at 1-855-481-7044 for routine matters. Additionally, Beacon clinical staff is available 24 hours a day seven days a week for authorization requests by calling 1-855-481-7044.

1.4 Contracting and Maintaining Network Participation

A Beacon "Network Provider" is an individual practitioner, private group practice, licensed outpatient agency, or facility that has been credentialed by Beacon and has signed a Provider Services Agreement (PSA) with Beacon and Humana. Network Providers agree to provide behavioral health and/or substance use Covered Services to Members, to accept reimbursement according to the rates as set forth in each Provider's PSA, and to adhere to all other terms in the PSA including this Provider Manual Appendix.

Beacon Network Providers who maintain approved credentialing status remain active Network Providers unless the PSA is terminated in accordance with the terms and conditions set forth therein. In cases where a Network Provider is terminated, such Providers may notify the Member of their termination. Beacon will also always notify Members when their Provider has been terminated and work to transition Members to another Network Provider to avoid unnecessary disruption of care.

1.5 About This Provider Manual Appendix

This Behavioral Health Provider Policy and Procedure Manual Appendix (referred to herein as the "Appendix" or the "Manual") is a legal document incorporated by reference as part of each Provider's Beacon Provider Services Agreement or Humana Provider Participation Agreement.

The Manual serves as an administrative guide outlining Beacon's policies and procedures governing network participation, service provision, claims submission, quality management and improvement requirements, in Chapters 1–3. Detailed information regarding clinical processes, including authorizations, utilization review, care management, reconsiderations and Provider Appeals are found in Chapters 4 and 5. Chapter 6 covers billing transactions. Beacon's level-of-care criteria (LOCC) are accessible through eServices or by calling Beacon at 1-855-481-7044. Additional information is can be found on the Beacon Provider portal at www.beaconhs.com/Providers.

The Manual is posted on both Humana and Beacon's websites and on Beacon's eServices; only the version on eServices includes Beacon's LOCC. Providers may also request a printed copy of the Manual by calling 1-855-481-7044.

Updates to the Manual as permitted by the Provider Services Agreement will be posted on the Humana and Beacon websites, and notification may also be sent by postal mail and/or electronic mail. Beacon provides notification to Network Providers at least 60 days prior to the effective date of any policy or procedural change that impacts Network Providers, such as modification in payment or covered services. Beacon provides 60 days' notice unless the change is mandated sooner by State or Federal requirements.

1.6 Transactions and Communications with Beacon

Beacon's website, www.beaconhealthstrategies.com, contains answers to frequently asked questions, Beacon's clinical practice guidelines, clinical articles, links to numerous clinical resources, and important news for Network Providers. As described below, eServices and EDI are also accessed through the website.

Electronic Media

To streamline Network Providers' business interactions with Beacon, we offer three Provider tools:

a) eServices
On eServices, Beacon's secure web portal supports all Provider transactions, while saving Providers' time, postage expense, billing fees, and reducing paper waste. eServices is completely free to Beacon Network Providers contracted for Humana and is accessible through www.beaconhealthstrategies.com 24 hours a day, seven days a week.

Many fields are automatically populated to minimize errors and improve claim approval rates on first submission. Claim status is available within two hours of electronic submission, all transactions generate printable confirmation, and transaction history is stored for future reference.

Because eServices is a secure site containing Member-identifying information, users must register to open an account. There is no limit to the number of users, and the designated account administrator at each Provider practice and organization controls which users can access each eServices features.

Click here to register for an eServices account; have your practice/organization's NPI and tax identification number available. The first user from a Provider organization or practice will be asked to sign and fax the eServices terms of use, and will be designated as the account administrator unless/until another designee is identified by the Provider organization. Beacon activates the account administrator's account as soon as the terms of use are received.

Subsequent users are activated by the account administrator upon registration. To fully protect Member confidentiality and privacy, Providers must notify Beacon of a change in account administrator, and when any users leave the practice.

The account administrator should be an individual in a management role, with appropriate authority to manage other users in the practice or organization. The Provider may reassign the account administrator at any time by emailing provider. relations@beaconhs.com.

b) Interactive Voice Recognition

Interactive voice recognition (IVR) is available to Providers as an alternative to eServices. It provides accurate, up-to-date information by telephone, and is available for selected transactions at 1-888-210-2018.

In order to maintain compliance with HIPAA and all other Federal and State confidentiality/privacy requirements, Network Providers must have their practice or organizational Tax Identification Number (TIN), National Provider Identifier (NPI), as well as Member's full name, Plan ID and date of birth, when verifying eligibility through eServices and through Beacon's IVR.

c) Electronic Data Interchange

Electronic data interchange (EDI) is available for claim submission and eligibility verification directly by Providers to Beacon or via an intermediary. For information about testing and setup for EDI, download Beacon's 837 and 835 companion guides.

Beacon accepts standard HIPAA 837 professional and institutional healthcare claim transactions and provides 835 remittance advice response transactions.

To set up an EDI connection, view the companion guide located on Beacon's Provider Portal at www.beaconhs.com/providers then contact edi.operations@beaconhs.com. You may submit any technical and business-related questions to the same address. To submit EDI claims through an intermediary, contact the intermediary for assistance. If using Emdeon, use Beacon's Emdeon Payer ID 43324 and Beacon's Health Plan 054.

TABLE 1-1: ELECTRONIC TRANSACTIONS AVAILABILITY

Transaction/Capability	eServices at beaconhealthoptions.com	IVR 1-888-210-2018	EDI at beacon-healthoptions.com
Verify Member eligibility, benefits and copayment	Yes	Yes	
Check number of visits available	Yes	Yes	
Submit authorization requests	Yes		
View authorization status	Yes	Yes	
Update practice information	Yes		
Submit claims	Yes		Yes (HIPAA 837)
Upload EDI claims to Beacon and view EDI upload history	Yes		Yes (HIPAA 837)
View claims status	Yes	Yes	
Print claims reports and graphs	Yes		

Download Electronic Remittance Advice	Yes		
EDI acknowledgment and submission reports	Yes		Yes (HIPAA 835)
Pend authorization requests for internal approval	Yes		
Access Beacon's level-of-care criteria and Provider Manual	Yes		

Email

Beacon encourages Providers to communicate with Beacon by email addressed to provider. relations@beaconhs.com.

Throughout the year Beacon sends Network Providers alerts related to regulatory requirements, protocol changes, helpful reminders regarding claim submission, etc. In order to receive these notices in the most efficient manner, we strongly encourage you to enter and update email addresses and other key contact information for your practice, through eServices.

Communication of Member Information

In keeping with HIPAA requirements, Providers are reminded that personal health information (PHI) should not be communicated via email, other than through Beacon's eServices. PHI may be communicated by telephone or secure fax.

It is a HIPAA violation to include any patient identifying information or protected health information in nonsecure email through the Internet.

1.7 Access Standards

Humana Members may access behavioral health services 24 hours a day, seven days a week by contacting Humana's Member services line 1-855-481-7044. The main Humana line includes an option for connecting directly to Beacon Health Options Member services for emergencies or authorization requests for acute levels of care. For most Members, referrals are not required to access behavioral health services. Authorization and referrals are never required for emergency services.

Humana and Beacon adhere to State and National Committee for Quality Assurance (NCQA) guidelines for access standards for Member appointments. Network Providers must adhere to the following:

TABLE 1-2: APPOINTMENT STANDARDS AND AFTER-HOURS ACCESSIBILITY

Type of Care	Appointment Availability
Emergency Care with Crisis Stabilization	Within twenty-four (24) hours
Urgent Care	Within forty-eight (48) hours
Post Discharge from Acute Hospitalization	Within seven days of discharge
Other routine referrals/ appointments	Within sixty (60) days

Access standards for Humana's behavioral health network are established to ensure that Members have access to services within thirty (30) miles or a maximum of thirty (30) minutes of their address in urban areas, and sixty (60) miles or a maximum of sixty (60) minutes of their address in rural areas.

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

TABLE 1-2: APPOINTMENT STANDARDS AND AFTER-HOURS ACCESSIBILITY

Service Availability	Hours of Operation:
On-call	• 24-hour on-call services for all Members in treatment; and • Ensure that all Members in treatment are aware of how to contact the treating or covering Provider after hours and during Provider vacations.
Crisis Intervention	• Services must be available 24 hours per day, seven days per week; • Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours; and • After hours, Providers should have a live telephone answering service or an answering machine that specifically directs a Member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room.
Outpatient Services	• Outpatient Providers should have services available Monday – Friday from 9 a.m. – 5 p.m. at a minimum; and • Evening and/or weekend hours also should be available at least two days per week.
Interpreter Services	• Under State and Federal law, Providers are required to provide interpreter services to communicate with individuals with limited English proficiency.
Cultural Competency	• Providers must ensure that Members have access to medical interpreters, signers and TTY services to facilitate communication when necessary and ensure that clinicians and agencies are sensitive to the diverse needs of Humana Members.

Medical Homes

All Providers are encouraged to consider an affiliation with a Medical Home. Some Providers may serve as a Medical Home, which is designed to provide fully integrated care for Members. For further information on the Medical Home model, please contact us at 1-855-481-7044.

Members with Disabilities

Provider locations shall be accessible for Humana Members with disabilities. As necessary to serve Members, Provider locations where Members receive services shall be compliant with the Adults with Disabilities Act (ADA). Providers may be required to attest that their facilities are ADA compliant.

Providers are required to meet these standards, and to notify Beacon if they are temporarily or permanently unable to meet the standards. If a Provider fails to provide services within these access standards notice is sent out within one business day informing the member and Provider that the waiting time access standard was not met.

1.8 Provider Credentialing and Recredentialing

Beacon conducts a rigorous credentialing process for Network Providers based on Centers for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA) guidelines. All Providers must be approved for credentialing by Beacon in order to participate in Beacon's behavioral health services network, and must comply with recredentialing standards by submitting requested information. Private solo and group practice clinicians are individually credentialed, while facilities are credentialed as organizations.

To request credentialing information and an application(s), please email provider.relations@beaconhs.com.

Provider Training

Please see subsection 8 of Section III of this Appendix, below.

1.9 Prohibition on Billing Members

Health Plan Members may not be billed for any covered service or any balance after reimbursement by Beacon except for any applicable copayment. Further, Providers may not charge Demonstration or ICP Members for any services that are not deemed Medically Necessary upon clinical review or which are administratively denied. It is the Provider's responsibility to check benefits prior to beginning treatment for any Demonstration or ICP Member and to follow the procedures set forth in this Manual.

Out-of-Network Providers

Out-of-network behavioral health benefits are limited to those covered services that are not available in the existing Humana/Beacon network, emergency services and transition services for Members who are currently in treatment with an out-of-network Provider who either is not a part of the network or who is in the process of joining the network, or otherwise required by Humana's contract with the State. Out-of-network Providers must complete a single case agreement (SCA) with Beacon. Out-of-network Providers may provide one evaluation visit for Humana Members without an authorization upon completion and return of the signed SCA. After the expiration of existing authorizations, services provided must be authorized by Beacon. Authorization requests for outpatient services can be obtained by calling 1-855-481-7044. If this process is not followed, Beacon may administratively deny the services and the out-of-network Provider must hold the Member harmless.

Out-of-network Providers who wish to join Beacon's network should contact our network department by calling 1-855-481-7044.

Provider Database

Beacon and Humana maintain a database of Provider information as reported to us by Providers. This database can be found on Beacon's website at www.beaconhs.com. A hard copy can be requested through 1-855-481-7044. The accuracy of this database is critical to operations, for such essential functions as:

- Member referrals
- Regulatory reporting requirements

- Network monitoring to ensure Member access to a full continuum of services across the entire geographic service area; and
- Network monitoring to ensure compliance with quality and performance standards including appointment access standards.

Provider-reported hours of operation and availability to accept new Members are included in Beacon's Provider database, along with specialties, licensure, language capabilities, addresses and contact information. This information is visible to Members on our website and is the primary information source for us to use when assisting Members with referrals. In addition to contractual and regulatory requirements pertaining to appointment access, up-to-date practice information is equally critical to ensuring appropriate referrals to available appointments. The table below lists required notifications. Most of these can be updated via Beacon's eServices portal or by email.

TABLE 1-3: REQUIRED NOTIFICATIONS

Type of Information
General Practice Information
Change in address or telephone number of any service
Addition or departure of any professional staff
Change in linguistic capability, specialty or program
Discontinuation of any covered service listed in the Behavioral Health Services Agreement
Change in licensure or accreditation of Provider or any of its professional staff
Change in licensure or accreditation of Provider or any of its professional staff
Change in hours of operation
Is no longer accepting new Members
Is available during limited hours or only in certain settings;
Has any other restrictions on treating Members
Is temporarily or permanently unable to meet Beacon standards for appointment access
Change in designated account administrator for the Provider's eServices accounts
Merger, change in ownership, or change of tax identification number;
Where adding a site, service or program not previously included in the Behavioral Health Services Agreement, remember to specify: a) Location; and b) Capabilities of the new site, service or program.

Adding Sites, Services and Programs

Your contract with Beacon is specific to the sites, rates and services for which you originally specified in your PSA.

To add a site, service or program not previously included in your PSA, you should notify Beacon of the location and capabilities of the new site, service or program. Beacon will coordinate with Humana to determine whether the site, service or program meets an identified geographic, cultural/linguistic and/or specialty need in our network.

2. Members, Benefits and Member-related Policies

2.1 Covered Services

Humana covers behavioral health and substance use services via Beacon which are provided to Members located in the Greater Chicago service area, including the counties of Cook, Du Page, Kane, Kankakee, Lake and Will. Under the Health Plan, the following levels of care are covered, provided that such services are Medically Necessary, delivered by contracted Network Providers (or as part of a Member's transition plan if Provider is not in network), and that the authorization procedures outlined in this Manual are followed. Please refer to your contract with Beacon for specific information about procedure and revenue codes and rates for each service.

- Outpatient Behavioral Health and Substance Use Services
- Community-based (Rule 132) Mental Health Services
- Partial Hospitalization
- Intensive Outpatient Services
- Division on Alcohol and Substance Use Services
- Inpatient Hospitalization
- Crisis Stabilization and Observation
- ER Services

Access to behavioral health treatment is an essential component of a comprehensive health care delivery system. Plan Members may access behavioral health services by self-referring to a network Provider, by calling Beacon, or by referral through acute or emergency room encounters. Members may also access behavioral health services by referral from their primary care practitioner (PCP). Some behavioral health and substance use services for Demonstration and/or ICP Members may require referral from the Member's PCP. Please contact Beacon for more information about referral requirements. Network Providers are expected to coordinate care with a Member's PCP and other treating Providers whenever possible.

Additional Benefit Information

- Benefits do not include payment for behavioral healthcare services that are not Medically Necessary.
- Neither Beacon nor the Health Plan is responsible for the costs of investigational drugs or devices or the costs of nonhealthcare services such as the costs of managing research or the costs of collecting data that is useful for the research project, but not Medically Necessary for the Member's care.
- Authorization may be required for all services.
- Opioid Maintenance is not a covered benefit except emergency services.
- Detailed information about authorization procedures is covered in Chapter 4 of this Manual.

2.2 Member Rights and Responsibilities

MEMBER RIGHTS

Humana and Beacon are firmly committed to ensuring that Members are active and informed participants in the planning and treatment phases of their behavioral care. We believe that Members become empowered through ongoing collaboration with their healthcare Providers, and that collaboration among Providers is also crucial to achieving positive healthcare outcomes.

Members must be fully informed of their rights to access treatment and to participate in all aspects of treatment planning. Members may request assistance from Beacon or Humana in filing an Appeal or a State hearing once their Appeal rights have been exhausted. Member rights and responsibilities, generally, are outlined above in Section I of this Appendix.

Right to Submit a Complaint or Concern to Beacon

Members and their legal guardians have the right to file a Complaint or Grievance with Beacon or the Plan regarding any of the following. Member Grievances will be handled directly by Humana.

- The quality of care delivered to the Member by a Beacon network Provider
- The Beacon utilization review process
- The Beacon network of services
- The procedure for filing a Complaint or Grievance as described in Chapter 3

Right to Contact Beacon Ombudsperson

Members have the right to contact Beacon's Office of Ombudsperson to obtain a copy of Beacon's Member Rights and Responsibilities statement. The Beacon Ombudsperson may be contacted at 1-855-481-7044 or by TTY at 1-855-539-5884.

Right to Make Recommendations About Member Rights and Responsibilities

Members have the right to make recommendations directly to Beacon regarding Beacon's Member's Rights and Responsibilities statement. Members should direct all recommendations and comments to Beacon's Ombudsperson. All recommendations will be presented to the appropriate Beacon review committee. The committee will recommend changes to the policies as needed and as appropriate.

Posting Member Rights and Responsibilities

All Network Providers must display, in a highly visible and prominent place, a statement of Member's Rights and Responsibilities. This statement must be posted and made available in languages consistent with the demographics of the population(s) served. This statement can either be Beacon's statement or a comparable statement consistent with the Provider's State license requirements.

Informing Members of Their Rights and Responsibilities

Providers are responsible for informing Members of their rights and respecting these rights. In addition to a posted statement of Member rights, Providers are also required to:

- Distribute and review a written copy of Member Rights and Responsibilities at the initiation of every new treatment episode and include in the Member's medical record signed documentation of this review
- Inform Members that Beacon does not restrict the ability of Network Providers to communicate openly with Plan Members regarding all treatment options available to them including medication treatment regardless of benefit coverage limitations
- Inform Members that Beacon does not offer any financial incentives to its Network Provider community for limiting, denying, or not delivering Medically Necessary treatment to Plan Members
- Inform Members that clinicians working at Beacon do not receive any financial incentives to limit or deny any Medically Necessary care

Nondiscrimination Policy and Regulations

Providers agree to treat Plan Members without discrimination. Providers may not refuse to accept and treat a Health Plan Member on the basis of his/her income, physical or mental condition, age, gender, sexual orientation, religion, creed, color, physical or mental disability, national origin, English proficiency, ancestry, marital status, veteran's status, occupation, claims experience, duration of coverage, race/ethnicity, pre-existing conditions, health status or ultimate payer for services. In the event that Provider does not have the capability or capacity to provide appropriate services to a Member, Provider should direct the Member to call Beacon for assistance in locating needed services.

Network Providers may not close their practice to Health Plan Members unless it is closed to all patients. The exception to this rule is that a Provider may decline to treat a Member for whom it does not have the capability or capacity to provide appropriate services. In that case, the Provider should either contact Beacon or have the Member call Beacon for assistance in locating appropriate services.

State and Federal laws prohibit discrimination against any individual who is a Member of Federal, State, or local public assistance, including medical assistance or unemployment compensation, solely because the individual is such a Member.

It is our joint goal to ensure that all Members receive Medically Necessary behavioral health care that is accessible, respectful, and maintains the dignity of the Member.

Confidentiality of Member Information

All Providers are expected to comply with Federal, State and local laws regarding access to Member information. With the enactment of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Members give consent for the release of information regarding treatment, payment and healthcare operations at the signup for health insurance. Treatment, payment and healthcare operations involve a number of different activities, including, but not limited to:

- Submission and payment of claims;
- Seeking authorization for extended treatment;
- QI initiatives, including information regarding the diagnosis, treatment and condition of Members in order to ensure compliance with contractual obligations;
- Member information reviews in the context of management audits, financial audits or program evaluations; and
- Chart reviews to monitor the provision of clinical services and ensure that authorization criteria are applied appropriately.

Member Consent

At every intake and admission to treatment, Providers should explain the purpose and benefits of communication to the Member's PCP and other relevant Providers. The behavioral health clinician should then ask the Member to sign a statement authorizing the clinician to share clinical status information with the PCP and for the PCP to respond with additional Member status information. A sample form is available at www.beaconhs.com (See Provider Tools Web page) or Providers may use their own form; the form must allow the Member to limit the scope of information communicated.

Members can elect to authorize or refuse to authorize release of any information, except as specified in the previous section, for treatment, payment and operations. Whether consenting or declining, the Member's signature is required and should be included in the medical record. If a Member refuses to release information, the Providers should clearly document the Member's reason for refusal in the narrative section on the form. In addition, the Provider should advise the Member that if they refuse authorization to release information for payment purposes, they will be held personally responsible for payment outside their Health Plan.

Confidentiality of Members' HIV-related Information

At every intake and admission to treatment, Providers should explain the purpose and benefits of Beacon works in collaboration with the Plan to provide comprehensive health services to Members with health conditions that are serious, complex, and involve both medical and behavioral health factors. Beacon coordinates care with Health Plan medical and disease management programs and accepts referrals for behavioral healthcare management from the Health Plan. Information regarding HIV infection, treatment protocols and standards, qualifications of HIV/AIDS treatment specialists, and HIV/AIDS services and resources, medications, counseling and testing is available directly from Health Plan. Beacon will assist behavioral health Providers or Members interested in obtaining any of this information by referring them to the Health Plan's care management department. Beacon limits access to all health-related information, including HIV-related information and medical records, to staff trained in confidentiality and the proper management of patient information. Beacon's care management protocols require Beacon to provide any Health Plan Member with assessment and referral to an appropriate treatment source. It is Beacon's policy to follow Federal and State information laws and guidelines concerning the confidentiality of HIV-related information.

Humana Health Plan Member Eligibility

Possession of a Health Plan Member identification card does not guarantee that the Member is eligible for benefits. Providers are strongly encouraged to check Member eligibility frequently.

The following resources are available to assist in eligibility verification:

TABLE 2-1: MEMBER ELIGIBILITY VERIFICATION TOOLS

Online	Via Telephone
Beacon's eServices	1-888-210-2018 Beacon's integrated voice recognition (IVR)

Providers may also use the Humana secure Provider Portal online to check Member eligibility, or call Provider Services.

Provider Services:

Provider Portal

Click on "Member Eligibility" on the left, which is the first tab.

- Sign in to https://www.beaconhs.com and select Providers from the menu options.
- Using our secure Provider Portal, you can check Humana Member eligibility up to 24 months after the date of service. You can search by date of service plus any one of the following: Member name and date of birth, case number, Medicaid (MMIS) number, or Humana Member ID number. You can submit multiple Member ID numbers in a single request.

- Call our automated Member eligibility verification system at 1-855-481-7044 from any touch-tone phone and follow the appropriate menu options to reach our automated Member-eligibility verification system. The automated system, available 24 hours a day, will prompt you to enter the Member ID number and the month of service to check eligibility.

In order to maintain compliance with HIPAA and all other Federal and State confidentiality/ privacy requirements, Providers must have their practice or organizational TIN, NPI, as well as Member's full name, Plan ID and date of birth, when verifying eligibility through eServices and through Beacon's IVR.

The Beacon Clinical Department may also assist the Provider in verifying the Member's enrollment in the Humana Health Plan when authorizing services. Due to implementation of the Privacy Act, Beacon requires the Provider to have ready specific identifying information (Provider ID number, Member's full name and date of birth) to avoid inadvertent disclosure of Member sensitive health information.

Please Note: Member eligibility information on eServices and through IVR is updated every night. Eligibility information obtained by phone is accurate as of the day and time it is provided by Beacon. Beacon cannot anticipate, and is not responsible for, retroactive changes or disenrollments reported at a later date. Providers should check eligibility frequently.

3. Quality Management and Improvement

3.1 QM & I Program Overview

TABLE 3-1: PROGRAM OVERVIEW

Program Description	Program Principles	Program Goals and Objectives
Beacon administers, on behalf of the Health Plan, a Quality Management and Improvement (QM & I) program whose goal is to continually monitor and improve the quality and effectiveness of behavioral health services delivered to Members. Beacon's QM & I Program integrates the principles of continuous quality improvement (CQI) throughout our organization and the Provider network.	Continually evaluate the effectiveness of services delivered to Health Plan Members; • Identify areas for targeted improvements; • Develop QI action plans to address improvement needs; and • Continually monitor the effectiveness of changes implemented, over time.	• Improve the healthcare status of Members; • Enhance continuity and coordination among behavioral healthcare Providers and between behavioral healthcare and physical healthcare Providers; • Establish effective and cost efficient disease management programs, including preventive and screening programs, to decrease incidence and prevalence of behavioral health disorders; • Ensure Members receive timely and satisfactory service from Beacon and network Providers; • Maintain positive and collaborative working relationships with network practitioners and ensure Provider satisfaction with Beacon services; and • Responsibly contain healthcare costs.

Provider Role

Humana and Beacon employ a collaborative model of continuous QM & I, in which Provider and Member participation is actively sought and encouraged. Humana and Beacon require each Provider to have its own internal QM & I Program to continually assess quality of care, access to care and compliance with Medical Necessity criteria.

All Providers are expected to provide Members with disease-specific information and preventive care information that can assist the Member in understanding his/her illness and help support their recovery. Member education should be person-centered, recovery-focused and promote compliance with treatment directives and encourage self-directed care.

To participate in Beacon's Provider Advisory Council, email provider.relations@beaconhs.com. Members who wish to participate in the Member Advisory Council should contact the Member Services Department.

Quality Monitoring

Beacon monitors Provider activity and utilizes the data generated to assess Provider performance related to quality initiatives and specific core performance indicators. Findings related to Provider compliance with performance standards and measures are also used in credentialing and recredentialing activities, benchmarking, and to identify individual Provider and network-wide improvement initiatives. Humana and Beacon's quality monitoring activities include, but are not limited to:

- Site visits;
- Treatment record reviews;
- Satisfaction surveys;
- Internal monitoring of timeliness and accuracy of claims payment, Provider compliance with performance standards including, but not limited to:
    - o Timeliness of ambulatory follow-up after behavioral health hospitalization;
    - o Discharge Planning Activities;
    - o Communication with Member PCPs, other behavioral health Providers, government and community agencies;
    - o Tracking of adverse incidents, Complaints, Grievances and appeals; and
    - o Other quality improvement activities.

On a quarterly basis, Beacon's QM & I Department aggregates and trends all data collected and presents the results to the QI Committee for review. The QI Committee may recommend initiatives at individual Provider sites and throughout Beacon's behavioral health network as indicated.

A record of each Provider's adverse incidents and any Complaints, Grievances or appeals pertaining to the Provider, is maintained in the Provider's credentialing file, and may be used by Beacon and Humana in profiling, recredentialing and network (re)procurement activities and decisions.

3.2 Treatment Records

Treatment Record Reviews

Beacon reviews Member charts and utilizes data generated to monitor and measure Provider performance in relation to Beacon's Treatment Record Standards and specific quality initiatives established each year: The following elements are evaluated in addition to any Illinois State specific regulatory requirements around chart review for special services such as Rule 132 services.

- Use of screening tools for diagnostic assessment of substance use, adolescent depression and ADHD;
- Continuity and coordination with primary care Providers and other treaters;
- Explanation of Member Rights and Responsibilities;
- Inclusion of all applicable required medical record elements as required by the State as identified in administrative regulations and service manuals, and NCQA; and
- Allergies and adverse reactions, medications, physical exam and evidence of advance directives.

Humana and Beacon may conduct chart reviews on-site at a Provider facility, or may ask a Provider to copy and send specified sections of a Member's medical record to Beacon. Any questions that a Provider may have regarding Beacon's access to the Plan Member information should be directed to Beacon's privacy officer, Elaine Stone at Elaine.stone@beaconhs.com.

HIPAA regulations permit Providers to disclose information without patient authorization for the following reasons: oversight of the healthcare system, including quality assurance activities. Beacon chart reviews fall within this area of allowable disclosure.

Treatment Record Standards

To ensure that the appropriate clinical information is maintained within the Member's treatment record, Providers must follow the documentation requirements below. All documentation must be clear and legible. Providers should also adhere to State guidelines around treatment records, such as Rule 132 documentation guidelines, where indicated.

TABLE 3-2: TREATMENT DOCUMENTATION STANDARDS

Member Identification Information	The treatment record contains the following Member information: • Member name and Health Plan ID number on every page; • Member's address; • Employer or school; • Home, work, and cellular (if applicable) telephone number; • Marital/legal status; • Appropriate consent forms; and • Guardianship information, if applicable.

The facility clinician making Informed Member Consent for Treatment	The treatment record contains signed consents for the following: • Implementation of the proposed treatment plan; • Any prescribed medications; • Consent forms related to interagency communications; • Individual consent forms for release of information to the Member's PCP and other behavioral health Providers, if applicable; each release of information to a new party (other than Beacon or the Health Plan) requires its own signed consent form; • Consent to release information to the payer or MCO (In doing so, the Provider is communicating to the Member that treatment progress and attendance will be shared with the payer.); • For adolescents ages 12–17, the treatment record contains consent to discuss behavioral health issues with their parents; and • Signed document indicating review of patient's rights and responsibilities.
Medication Information	Treatment records contain medication logs clearly documenting the following: • All medications prescribed; • Dosage of each medication; • Dates of initial prescriptions; • Information regarding allergies and adverse reactions; and • Lack of known allergies and sensitivities to substances.
Medical and Psychiatric History	Treatment record contains the Member's medical and psychiatric history including: • Previous dates of treatment; • Names of Providers; • Therapeutic interventions; • Effectiveness of previous interventions; • Sources of clinical information; • Relevant family information; • Results of relevant laboratory tests; and • Previous consultation and evaluation reports. • Documentation of Advance Directives
Substance Use Information	Documentation for any Member 12 years and older of past and present use of the following: • Cigarettes; • Alcohol; and Illicit, prescribed, and over-the-counter drugs.
Adolescent Depression Information	Documentation for any Member 13-18 years screened for depression • If yes, was a suicide assessment conducted; and • Was the family involved with treatment?
ADHD Information	Documentation of Members ages 6-12 assessed for ADHD • Was family involved with treatment; and • Is there evidence of the Member receiving psychopharmacological treatment?

Diagnostic Information	• Risk management issues (e.g., imminent risk of harm, suicidal ideation/intent, elopement potential) are prominently documented and updated according to Provider procedures; • All relevant medical conditions are clearly documented, and updated as appropriate; • Member's presenting problems and the psychological and social conditions that affect their medical and psychiatric status; A complete mental status evaluation is included in the treatment record, which documents the Member's: a. Affect; b. Speech; c. Mood; d. Thought control, including memory; e. Judgment; f. Insight; g. Attention/concentration; h. Impulse control; i. Initial diagnostic evaluation and DSMIV diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information; and j. Diagnoses updated at least quarterly.
Treatment Planning	The treatment record contains clear documentation of the following: • Initial and updated treatment plans consistent with the Member's diagnoses, goals and progress; • Objective and measurable goals with clearly defined time frames for achieving goals or resolving the identified problems; • Treatment interventions utilized and their consistency with stated treatment goals and objectives; • Member, family and/or guardian's involvement in treatment planning, treatment plan meetings and discharge planning; and • Copy of Outpatient Review Form(s) submitted, if applicable.
Treatment Documentation	The treatment record contains clear documentation of the following: • Ongoing progress notes that document the Member's progress towards goals, as well as their strengths and limitations in achieving said goals and objectives; • Referrals to diversionary levels of care and services if the Member requires increased interventions resulting from homicidality, suicidality or the inability to function on a day-to-day basis; • Referrals and/or Member participation in preventive and self-help services (e.g., stress management, relapse prevention, Alcoholics Anonymous, etc.) is included in the treatment record; and • Member's response to medications and somatic therapies.

Coordination and Continuity of Care	The treatment record contains clear documentation of the following: • Documentation of communication and coordination between behavioral health Providers, primary care physicians, ancillary Providers, and healthcare facilities; and • Dates of follow-up appointments, discharge plans and referrals to new Providers.
Additional Information for Outpatient Treatment Records	These elements are required for the outpatient medical record: • Telephone intake/request for treatment; • Face sheet; • Termination and/or transfer summary, if applicable; and • The following clinician information on every entry (e.g., progress notes, treatment notes, treatment plan, and updates) should include the following treating clinician information: a. Clinician's name; b. Professional degree; c. Licensure, d. NPI or Beacon Identification number, if applicable; and e. Clinician signatures with dates.
Additional Information for Inpatient and Diversionary Levels of Care	These elements are required for inpatient medical records: • Referral information (ESP evaluation); • Admission history and physical condition; • Admission evaluations; • Medication records; • Consultations; • Laboratory and X-ray reports; and • Discharge summary and Discharge Review Form.
Information for Children and Adolescents	A complete developmental history must include the following information: • Physical, including immunizations; • Psychological; • Social; • Intellectual; • Academic; and • Prenatal and perinatal events are noted.

In addition to the requirements above, for each MMAI Demonstration Member, Providers are also required to capture the following information in the Member's medical record:

- Date of birth;
- A summary of significant surgical procedures;
- Description of chief complaint or purpose of visit, the objective diagnosis, medical findings, and the impression of the Provider;
- Identification of any studies ordered;
- Identification of any therapies administered and prescribed;
- Disposition, recommendations, instructions to the Member, evidence of whether there was follow-up and outcome of services;
- Immunization history;

- Summaries of all emergency services and care and hospital discharges with appropriate follow-up;
- Documentation of referral services and Member's medical records;
- All services provided by Provider (family planning services, preventive services, etc.);
- Primary language spoken by the Member and any translation needs of Member; and
- Identify Members needing communication assistance in the delivery of healthcare services.

Advance Directives

Beacon practices an integrated approach to advance directives between behavioral health and medical care Providers. As per Federal law (Patient Self-determination Act, 42 U.S.C.A. § 1396a[w] [West 1996]), Providers participating in the Medicare and Medicaid programs are required to furnish patients with information on advance directives. The information is to be given to patients upon admission to a facility or when provision of care begins. Documentation that the Member was provided with this information must be noted in the Member's treatment record. The documentation must also specify whether the Member has executed an Advanced Directive. The Member's Advance Directive decision should be periodically reviewed between the Provider, Member, and/or the Member's legal guardian (if applicable). This should be closely coordinated with the care manager around significant changes in the Member's condition, diagnosis, and/or level of care.

Illinois law allows for the following three types of advance directives: (1) healthcare power of attorney; (2) living will; and (3) mental health treatment preference declaration. Providers should ensure that Members are informed of these rights.

Forms and documentation regarding advanced directives can be downloaded from http://www.idph.state.il.us/public/books/advin.htm.

Performance Standards and Measures

To ensure a consistent level-of-care within the Provider network, and a consistent framework for evaluating the effectiveness of care, Beacon has developed specific Provider performance standards and measures. Behavioral health Providers are expected to adhere to the performance standards for each level of care they provide to Members, which include, but are not limited to:

- Communication with PCPs and other Providers treating shared Members; and
- Availability of routine, urgent and emergent appointments (See Chapter 4).

Practice Guidelines

Beacon and Humana promote delivery of behavioral health treatment based on scientifically proven methods. We have researched and adopted evidenced-based guidelines for treating the most prevalent behavioral health diagnoses, including guidelines for ADHD, substance use disorders, and child/adolescent depression, and posted links to these on our website. We strongly encourage Providers to use these guidelines and to consider these guidelines whenever they may promote positive outcomes for clients. Beacon monitors Provider utilization of guidelines through the use of claim, pharmacy and utilization data.

Beacon welcomes Provider comments about the relevance and utility of the guidelines adopted by Beacon, any improved client outcomes noted as a result of applying the guidelines, and about Providers' experience with any other guidelines. To provide feedback, or to request paper copies of the practice guidelines adopted by Beacon, contact us.

Outcome Measurement

Beacon strongly encourages and supports Providers in the use of outcome measurement tools for all Members. Outcome data is used to identify potentially high-risk Members who may need intensive behavioral health, medical, and/or social care management interventions. Humana requires that Providers document attempts to communicate with Member primary care Providers, with Member consent. Providers are expected to submit quarterly (monthly if applicable) reports to the Member's PCP on Member treatment and progress.

Beacon receives aggregate data by Provider including demographic information and clinical and functional status without Member-specific clinical information.

TABLE 3-3: COMMUNICATION BETWEEN BEHAVIORAL HEALTH PROVIDERS AND OTHER TREATERS

Communication Between Outpatient Behavioral Health Providers and PCPs, Other Treaters	Communication Between Inpatient/Diversionary Providers and PCPs, Other Outpatient Treaters
Outpatient behavioral health Providers are expected to communicate with the Member's PCP and other OP behavioral health Providers if applicable, as follows: • Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first; • Updates at least quarterly during the course of treatment; • Notice of initiation and any subsequent modification of psychotropic medications; and • Notice of treatment termination within two weeks. Behavioral Health Providers may use Beacon's Authorization for Behavioral Health Provider and PCP to Share Information and the Behavioral Health-PCP Communication Form available for initial communication and subsequent updates, on Beacon's Provider portal at www.beaconhs.com/provider, or their own form that includes the following information: • Presenting problem/reason for admission; • Date of admission; • Admitting diagnosis; • Preliminary treatment plan; • Currently prescribed medications; • Proposed discharge plan; and • Behavioral Health Provider contact name and telephone number.	With the Member's informed consent, acute care facilities should contact the PCP by phone and/or by fax, within 24 hours of a Member's admission to treatment. Inpatient and diversionary Providers also must alert the PCP 24 hours prior to a pending discharge, and must fax or mail the following Member information to the PCP within three days post-discharge: • Date of Discharge; • Diagnosis; • Medications; • Discharge plan; and • Aftercare services for each type, including: – Name of Provider; – Date of first appointment; – Recommended frequency of appointments; – Treatment plan. Inpatient and diversionary Providers should make every effort to provide the same notifications and information to the Member's outpatient therapist, if there is one.

Request for PCP response by fax or mail within three business days of the request to include the following health information: • Status of immunizations; • Date of last visit; • Dates and reasons for any and all hospitalizations; • Ongoing medical illness; • Current medications; • Adverse medication reactions, including sensitivity and allergies; • History of psychopharmacological trials; and • Any other medically relevant information. Outpatient Providers' compliance with communication standards is monitored through requests for authorization submitted by the Provider, and through chart reviews	Acute care Providers' communication requirements are addressed during continued stay and discharge reviews and documented in Beacon's Member record.

State Specific ICP and Demonstration Model of Care Requirements

Providers must follow the procedures below as per State guidelines:

- Facilitate referral of the Member to specialists or specialty care, behavioral healthcare services, health education classes and community resource agencies, when appropriate
- Integrate medical screening along with basic primary care services provided to demonstration and ICP Members; provide screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders
- Deliver evidence-based behavioral health treatment and establish protocols for referral to behavioral health specialty Providers
- Ensure confidentiality of Members' medical and behavioral health and personal information as required by State and Federal laws

Transitioning Members from One Behavioral Health Provider to Another

If a Member transfers from one behavioral health Provider to another, the transferring Provider must communicate the reason(s) for the transfer along with the information above (as specified for communication from behavioral health Provider to PCP), to the receiving Provider.

Routine outpatient behavioral health treatment by an out-of-network Provider is not an authorized service covered by Beacon. Members may be eligible for transitional care within 30 days after joining the Health Plan, or to ensure that services are culturally and linguistically sensitive, individualized to meet the specific needs of the Member, timely per Beacon's timeliness standards, and/or geographically accessible.

Follow-Up After Behavioral Health Hospitalization

All inpatient Providers are required to coordinate after-care appointments with community based Providers prior to the Member's discharge. Beacon's UM and care management staff can assist Providers in determining if the Member is actively engaged in treatment with a behavioral health Provider and assist with referrals to ensure that Members are discharged with a scheduled appointment. Members discharged from inpatient levels-of-care are scheduled for follow-up appointments within seven days of discharge from an acute care setting. Providers are responsible for seeing Members within that time frame and for reaching out to Members who miss their appointments within 24 hours of the missed appointment to reschedule. Beacon's care managers and aftercare coordinators assist in this process by sending reminders to Members; working to remove barriers that may prevent a Member from keeping his or her discharge appointment and coordinating with treating Providers. Network Providers are expected to aid in this process as much as possible to ensure that Members have the supports they need to maintain placement in the community and to prevent unnecessary readmissions.

Reportable Incidents and Events

Beacon requires that all Providers report adverse incidents, other reportable incidents and sentinel events involving the Humana Members to Beacon as follows by calling 1-855-481-7044.

TABLE 3-4: REPORTABLE INCIDENTS

	Adverse Incidents	Sentinel Events	Other Reportable Incidents
Incident/Event Description:	An adverse incident is an occurrence that represents actual or potential serious harm to the well-being of a Health Plan Member who is currently receiving or has been recently discharged from behavioral health services	A sentinel event is any situation occurring within or outside of a facility that either results in death of the Member or immediately jeopardizes the safety of a Health Plan Member receiving services in any level of care	An "other reportable incident" is any incident that occurs within a Provider site at any level of care, which does not immediately place a Health Plan Member at risk but warrants serious concern

Incidents/Events Include the Following:	All medico-legal or nonmedico-legal deaths • Any Absence Without Authorization (AWA) involving a Member who does not meet the criteria above • Any injury while in a 24-hour program that could or did result in transportation to an acute care hospital for medical treatment or hospitalization • Any sexual assault or alleged sexual assault • Any physical assault or alleged physical assault by a staff person or another patient against a Member	• All medico-legal deaths • Any medico-legal death is any death required to be reported to the Medical Examiner or in which the Medical Examiner takes jurisdiction • Any AWA involving a patient involuntarily admitted or committed and/or who is at high risk of harm to self or others • Any serious injury resulting in hospitalization for medical treatment • A serious injury is any injury that requires the individual to be transported to an acute care hospital for medical treatment and is subsequently medically admitted	• Any nonmedico-legal death; • Any AWA from a facility involving a Member who does not meet the criteria for a sentinel event as described above • Any physical assault or alleged physical assault by or against a Member that does not meet the criteria of a sentinel event • Any serious injury while in a 24 hour program requiring medical treatment, but not hospitalization • A serious injury, defined as any injury that requires the individual to be transported to an acute care hospital for medical treatment and is not subsequently medically admitted

Incidents/Events Include the Following: ***Continued***	• Any medication error or suicide attempt that requires medical attention beyond general first aid procedures • Any unscheduled event that results in the temporary evacuation of a program or facility (e.g., fire resulting in response by fire department).	• Any medication error or suicide attempt that requires medical attention beyond general first aid procedures • Any sexual assault or alleged sexual assault • Any physical assault or alleged physical assault by a staff person against a Member • Any unscheduled event that results in the evacuation of a program or facility whereby regular operations will not be in effect by the end of the business day and may result in the need for finding alternative placement options for Member	• Any unscheduled event that results in the temporary evacuation of a program or facility such as a small fire that requires fire department response. Data regarding critical incidents is gathered in the aggregate and trended on a quarterly basis for the purpose of identifying opportunities for quality improvement
Reporting	• Beacon's Clinical Department is available 24 hours a day; • Providers must call, regardless of the hour, to report such incidents;		
Method:	• Providers should direct all such reports to their Beacon clinical manager or UR clinician by phone • In addition, Providers are required to fax a copy of the Adverse Incident Report Form (for adverse and other reportable incidents and sentinel events) to Beacon's Ombudsperson at 1-888-204-5581 • Incident and event reports should not be emailed unless the Provider is using a secure messaging system.		
Prepare to Provide the Following:	Providers should be prepared to present: • All relevant information related to the nature of the incident • The parties involved (names and telephone numbers) • The Member's current condition		

4. Care Management

4.1 Care Coordination

Humana's Integrated Management and Chronic Illness program will provide a proactive and comprehensive system of care for enrolled Members living with chronic physical diseases, mental illness, substance use disorders and/or developmental and intellectual disabilities that promotes person-centered, integrated care across the spectrum of medical, behavioral, psycho-social and long-term services and supports. This approach is aimed at eliminating fragmented and often poorly coordinated healthcare and social services that historically plague effective treatment for these individuals and results in poor health status and ineffectual expenditures.

The description below is designed to provide a broad overview of Humana's care management program. Many Members may already receive community-based case management through the Community Mental Health Center network in Illinois. Humana and Beacon will engage existing case managers whenever possible to ensure continuity of care, avoid unnecessary disruption in services and multiple contacts for Members.

The Provider's participation is key and includes the following activities:

- Participation in Interdisciplinary Care Team (ICT) care conferences via phone, through exchange of written communications and possibly in person
- Participation in inbound and outbound communications to foster care coordination
- Promote Healthcare Effectiveness Data and Information Set (HEDIS®) and National Committee for Quality Assurance (NCQA) quality measures
- Provide all medical record documentation and information as requested to support Humana's fulfillment of State and Federal regulatory and accreditation obligations, e.g., HEDIS

Provider's Role and Responsibility in Care Coordination, Care Transitions, Comprehensive Medication Reviews and Preventive Screenings:

- Assure that Members are informed of specific healthcare needs requiring follow-up and that Members receive training in self-care, including medication adherence, and other measures they may take to promote their own health
- Ensure the Member receives appropriate specialty, ancillary, emergency and hospital care when needed, providing necessary referrals and communicating to specialists, hospitalists, SNFists, and other Providers the Member information that will assist them in consultation and recommending treatments, equipment and/or services for the Member.
- Provide coordination of care for Members who are homebound or have significant mobility limitations to ensure access to care through home visits by nurse practitioners or physicians.
- Track and document appointments, clinical fi treatment plans and care received by Members referred to specialists, other healthcare Providers or agencies to ensure continuity of care.
- Obtain authorizations and notify Humana for any out-of-network services when an in-network Provider of the specialty in question is not available in the geographical area.
- Work with Humana's Care Coordination team to arrange for a Member to receive a second opinion from a qualified in-network healthcare professional or arrange for the Member to obtain one outside the network, if a qualified in-network Provider is not available.

- Initiate or assist with the discharge or transfer of Members from an inpatient facility to the most medically appropriate level-of-care facility or back to the Member's home or permanent place of domicile; consider the availability of in-network facilities and obtain appropriate authorizations if using out-of-network facilities.
- Support, participate in, and communicate with the ICT, in person and/or in writing, in developing and implementing an individualized plan of care to facilitate effective care coordination.
- Provide timely access to medical records or information for quality management and other purposes, including audits, reviews of Complaints or appeals, HEDIS, and other studies, and promptly respond to recommendations for improvement by developing and enacting a corrective/improvement plan, as appropriate.
- Follow the preventive care guidelines set by the U.S. Preventive Services Task Force, and provide and document the preventive care services required by the NCQA for HEDIS Quality Assurance Reporting Requirements.

Provider Creation and Participation in Individualized Care Plans – The Individualized Care Plan is based on:

- Initial and ongoing HRA and comprehensive assessment results
- Claims history
- Plans developed for each Member by the ICT
- Include Member-driven goals, objectives and interventions
- Address specific services and benefits
- Provide measurable outcomes

Provider Participation as an Integral Member of the ICT:

The ICT is a team of caregivers from different professional disciplines who work together to deliver care services focused on care planning to optimize quality of life and to support the individual and/or family. The ICT may include:

- The Member and/or his or her authorized caregiver
- The Member's physicians and/or nurses
- Humana's care managers and coordinators
- Social workers and community social-service Providers
- Humana's and/or the Member's behavioral health professionals
- Humana's community health educators and resource-directory specialists

The physician-inclusive ICT model supports the following.

The physician's treatment and medication plans:

- The physician's goals via the Humana Cares team of nurses, social workers, pharmacy specialists and behavioral-health specialists
- Member education and enhancement of direct patient-physician communication
- Self-care management and informed healthcare decision-making
- Care coordination and care transitions
- Access and connections to additional community resources and Medicaid services
- Appropriate end-of-life planning

Expected Provider Communications and Reporting:

- Maintain frequent communication, in person or by phone, with the ICT including other Providers of care and services such as specialist physician, hospital and/or ancillary Providers to ensure continuity of care and effective care coordination.
- Immediately report actual or suspected child abuse, elder abuse or domestic violence to the local law enforcement agency by telephone and submit a follow-up written report to the local law enforcement agency within the time frames as required by law.
- Provide all medical record documentation and information as requested to support Humana's fulfillment of State and Federal regulatory and accreditation obligations, e.g., HEDIS, NCQA.

Working with Demonstration and ICP Members With a Mental Health Diagnosis:

- Facilitate referral of the Member to specialists or specialty care, behavioral health care services, health education classes and community resource agencies, when appropriate.
- Integrate medical screening along with basic primary care services provided to Demonstration and ICP Members; Provide screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.
- Deliver evidence-based behavioral health treatment and establish protocols for referral to behavioral health specialty Providers.
- Ensure confidentiality of Members' medical and behavioral health and personal information as required by State and Federal laws.

Understanding Chronic Conditions Prevalent within the Demonstration and ICP Population:

- Multiple chronic conditions increase the risks for poor outcomes such as mortality and functional limitations as well as the risk of high cost services such as hospitalizations and emergency room visits. Evidence proves that preventive care and frequent/consistent care of chronic conditions lowers the advent of major conditions and decreases use of emergency room visits and readmissions.
- Humana's Clinical Practice Guidelines, available to both affiliated and nonaffiliated Providers on Humana's website, adopt relevant, evidence-based medical and behavioral health guidelines (preventive and certain nonpreventive acute and chronic conditions) from recognized sources such as professional medical associations, voluntary health organizations and NIH Centers and Institutes.
- Humana provides chronic disease management services and support to promote self-management for individuals with chronic conditions.

State of Illinois Transition of Care Requirements

To meet the transition of care requirements of the State of Illinois, the following procedures will be followed by Humana and Beacon Providers:

- In those instances when the Member's care needs to be transitioned to a new Provider or Providers either during the transition period and once the transition period is over, the Care Coordinator follows the following procedures to ensure the Member receives ongoing care:
- Identify appropriate Providers in the Member's geographic area that meet cultural and linguistic needs
- Review the list of recommended Behavioral Health Providers with the Member

- Encourage Member to select a recommended Behavioral Health Provider, if unable, the Care Coordinator will select
- Assist Member in accessing an appointment with the identified Provider
- Obtain Member permission to share ICP and relevant assessment findings with selected Behavioral Health Provider
- Obtain Member permission for the exchange of relevant health information between new Behavioral Health Provider and PCP and other treaters

4.2 Utilization Management

Utilization management (UM) is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, care management, discharge planning and retrospective review.

Beacon's UM program is administered by licensed, experienced clinicians who are specifically trained in utilization management techniques and in Beacon's standards and protocols. All Beacon employees with responsibility for making UM decisions have been made aware that:

- All Mental Health UM decisions are based upon Beacon's Level of Care/Medical Necessity Criteria (LOCC); Substance Abuse level-of-care decisions are made based on the American Society of Addiction Medicine (ASAM) criteria
- Financial incentives based on an individual UM clinician's number of adverse determinations or denials of payment are prohibited
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization

Note that the information in this chapter, including definitions, procedures, and determination and notification time frames may vary for different lines of business based on differing regulatory requirements. Such differences are indicated where applicable.

Community-based Service Providers

All community-based service Providers (Rule 132 Providers) are expected to follow all regulations and guidelines set forth in Rule 59 ILAC 132.

4.3 Level-of-care Criteria (LOCC)

Beacon's LOCC are the basis for all Medical Necessity determinations; accessible through eServices, includes Beacon's specific LOCC for Illinois for each level of care. Providers can also contact us to request a printed copy of Beacon's LOCC.

Beacon's LOCC were developed from the comparison of national, scientific and evidence-based criteria sets, including, but not limited to, those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), Substance Use and Behavioral Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM). They are reviewed and updated annually or more often as needed to incorporate new treatment applications and technologies that are adopted as generally accepted professional medical practice.

Beacon's LOCC are applied to determine appropriate care for all Members. In general, Members are certified only if they meet the specific Medical Necessity criteria for a particular level-of-care. However, the individual's specific needs and the characteristics of the local service delivery system may also be taken into consideration.

4.4 Utilization Management Terms and Definitions

The definitions below describe utilization review including the types of the authorization requests and UM determinations used to guide Beacon's UM reviews and decision-making. All determinations are based upon review of the information provided and available to Beacon at the time.

TABLE 4-1: UM TERMS AND DEFINITIONS	
Adverse Determination:	A decision to deny, terminate or modify (an approval of fewer days, units or another level-of-care other than was requested, and with which the practitioner does not agree) an admission, continued inpatient stay, or the availability of any other behavioral healthcare service, for • failure to meet the requirements for coverage based on Medical Necessity • appropriateness of healthcare setting and level-of-care effectiveness • Health Plan benefits
Adverse Action:	The following actions or inactions by Beacon or the Provider organization: • Beacon's denial, in whole or in part, of payment for a service failure to provide covered services in a timely manner in accordance with the waiting time standards • Beacon's denial or limited authorization of a requested service, including the determination that a requested service is not a covered service • Beacon's reduction, suspension, or termination of a previous authorization for a service • Beacon's denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute adverse actions, including, but not limited to, denials based on the following: a. Failure to follow prior authorization procedures b. Failure to follow referral rules c. Failure to file a timely claim • Beacon's failure to act within the time frames for making authorization decisions • Beacon's failure to act within the time frames for making appeal decisions.
Nonurgent Concurrent Review & Decision	Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments. A nonurgent concurrent decision may authorize or modify requested treatment over a period of time or a number of days or treatments, or deny requested treatment, in a nonacute treatment setting.
Nonurgent Preservice Review & Decision	Any case or service that must be approved before the Member obtains care or services. A nonurgent preservice decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment, in nonacute treatment setting.
Postservice Review & Decision (Retrospective Decision)	Any review for care or services that have already been received. A postservice decision would authorize, modify or deny payment for a completed course of treatment where a preservice decision was not rendered, based on the information that would have been available at the time of a pre-service review.

Urgent Care Request & Decision	Any request for care or treatment for which application of the normal time period for a nonurgent care decision: • Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment • In the opinion of a practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that could not be adequately managed without the care or treatment that is requested
Urgent Concurrent Review Decision	Any review for a requested extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments in an acute treatment setting, when a Member's condition meets the definition of urgent care, above
Urgent Preservice Decision	Formerly known as a precertification decision, any case or service that must be approved before a Member obtains care or services in an inpatient setting, for a Member whose condition meets the definition of urgent care above. An urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment in an acute treatment setting

Authorization Procedures and Requirements

This section describes the processes for obtaining authorization for inpatient, community-based diversionary and outpatient levels of care, and for Beacon's Medical Necessity determinations and notifications. In all cases, the treating Provider, whether admitting facility or outpatient practitioner, is responsible for following the procedures and requirements presented, in order to ensure payment for properly submitted claims.

Administrative denials may be rendered when applicable authorization procedures, including time frames, are not followed. Members cannot be billed for services that are administratively denied due to a Provider not following the requirements listed in this Manual.

Member Eligibility Verification

The first step in seeking authorization is to determine the Member's eligibility. Since Member eligibility changes occur frequently, Providers are advised to verify a Health Plan Member's eligibility upon admission to, or initiation of treatment, as well as on each subsequent day or date of service to facilitate reimbursement for services.

Member eligibility can change, and possession of a Health Plan Member identification card does not guarantee that the Member is eligible for benefits. Providers are strongly encouraged to check Beacon's eServices or by calling IVR at 1-888-210-2018.

4.5 Emergency Services

Definition

Emergency services are those physician and outpatient hospital services, procedures, and treatments, including psychiatric stabilization and medical detoxification from drugs or alcohol, needed to evaluate or stabilize an emergency medical condition. The definition of an emergency is listed in your PSA.

Emergency care will not be denied; however, subsequent days do require pre-service authorization. The facility must notify Beacon as soon as possible and no later than 24 hours after an emergency admission and/or learning that the Member is covered by the Health Plan. If a Provider fails to notify Beacon of an admission, Beacon may administratively deny any days that are not prior-authorized.

Emergency Screening and Evaluation

Plan Members must be screened for an emergency medical condition by a qualified behavioral health professional from the hospital emergency room, mobile crisis team, or by an emergency service program. This process allows Members access to emergency services as quickly as possible and at the closest facility or by the closest crisis team.

After the evaluation is completed, the facility or program clinician should call Beacon to complete a clinical review, if admission to a level of care that requires precertification is needed. The facility/program clinician is responsible for locating a bed, but may request Beacon's assistance. Beacon may contact an out-of-network facility in cases where there is no timely or appropriate placement available within the network. In cases where there is no in-network or out-of-network psychiatric facility available, Beacon will authorize boarding the Member on a medical unit until an appropriate placement becomes available.

Beacon Clinician Availability

All Beacon clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures. Beacon clinicians are available 24 hours a day, seven days a week to receive crisis calls from providers for authorization of inpatient admission.

Members or, their guardians in emergency situations are directed to call Humana at 1-855-235-8530.

Disagreement Between PA and Attending Physician

For acute services, in the event that Beacon's Physician Advise (PA) and the emergency service physician do not agree on the service that the Member requires, the emergency service physician's judgment shall prevail and treatment shall be considered appropriate for an emergency medical condition, if such treatment is consistent with generally accepted principles of professional medical practice and is a covered benefit under the Member's program of medical assistance or medical benefits. All Beacon clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures.

4.6 Authorization Requirements

For a complete listing of covered services and authorization requirements, please refer to Attachment A.

Outpatient Treatment

Many Humana Members that you treat will have Individualized Care Plans and a care manager. It is critical that you communicate with the care manager about the services you plan to provide so that they can be included in the Member's care plan and be authorized appropriately. The care manager will assist you to optimize the benefits for each Member you treat. While traditional outpatient services do not require prior authorization, our care managers will work with the treating Providers to ensure that the Member is getting the care that he or she needs. Beacon will conduct outlier management of outpatient care in addition to care coordination.

Please refer to your contract for specific information about procedure and revenue codes that should be used for billing. Services that indicate "eRegister" will be authorized via Beacon's eServices portal. Providers will be asked a series of clinical questions to support Medical Necessity for the service requested. If sufficient information is provided to support the request, the service will be authorized. If additional information is needed, the Provider will be prompted to contact Beacon via phone to continue the request for authorization. While Beacon prefer Providers to make requests via eServices, we will work with Providers who do have technical or staffing barriers to requesting authorizations in this way.

Authorization decisions are posted on eServices within the decision time frames outlined in table 4-3. Providers receive an email message alerting them that a determination has been made. Beacon also faxes authorization letters to Providers upon request; however we strongly

encourage Providers to use eServices instead of receiving paper notices. Providers can opt out of receiving paper notices on Beacon's eServices portal. All notices clearly specify the number of units (sessions) approved, the time frame within which the authorization can be used, and explanation of any modifications or denials. All denials can be appealed according to the policies outlined in this Manual.

All forms can be found at beaconhealthstrategies.com under Provider.

Inpatient Services

All inpatient services (including inpatient ECT) require telephonic prior-authorization within 24 hours of admission. Providers should call Beacon at 1-855-481-7044 for all inpatient admissions, including detoxification that is provided on a psychiatric floor or in freestanding psychiatric facilities. All other requests for authorization for detoxification should be directed to Beacon at 1-855-481-7044. Continued-stay reviews require updated clinical information that demonstrates active treatment. Additional information about what is required during preservice and concurrent stay reviews is listed below.

TABLE 4-2: UM REVIEW REQUIREMENTS – INPATIENT AND DIVERSIONARY

The facility clinician making the request needs the following information for a preservice review: • Member's Health Plan Identification number • Member's name, gender, date of birth, and city or town of residence • Admitting facility name and date of admission • DSMIV diagnosis: All five axes are appropriate; Axis I and Axis V are required. (A provisional diagnosis is acceptable) • Description of precipitating event and current symptoms requiring inpatient psychiatric care • Medication history • Substance use history • Prior hospitalizations and psychiatric treatment • Member's and family's general medical and social history • Recommended treatment plan relating to admitting symptoms and the Member's anticipated response to treatment	**To conduct a continued-stay review, call a Beacon UR clinician with the following required information:** • Member's current diagnosis and treatment plan, including physician's orders, special procedures, and medications • Description of the Member's response to treatment since the last concurrent review • Member's current mental status, discharge plan, and discharge criteria, including actions taken to implement the discharge plan • Report of any medical care beyond routine is required for coordination of benefits with Health Plan (Routine medical care is included in the per diem rate)	Post-service reviews may be conducted for inpatient, diversionary or outpatient services rendered when necessary. To initiate a postservice review, call Beacon. If the treatment rendered meets criteria for a post service review, the UR clinician will request clinical information from the Provider including documentation of presenting symptoms and treatment plan via the Member's medical record. Beacon requires only those section(s) of the medical record needed to evaluate Medical Necessity and appropriateness of the admission, extension of stay, and the frequency or duration of service. A Beacon physician or psychologist advise completes a clinical review of all available information, in order to render a decision.

Authorization determinations are based on the clinical information available at the time the care was provided to the Member.

Members must be notified of all preservice and concurrent denial decisions. The service is continued without liability to the Member until the Member has been notified of the adverse determination. The denial notification letter sent to the Member or Member's guardian, practitioner, and/or Provider includes the specific reason for the denial decision, the Member's presenting condition, diagnosis and treatment interventions, the reason(s) why such information does not meet the Medical Necessity criteria, reference to the applicable benefit provision, guideline, protocol or criterion on which the denial decision was based, and specific alternative treatment option(s) offered by Beacon, if any. Based on State and/or Federal statutes, an explanation of the Member's appeal rights and the appeals process is enclosed with all denial letters. Notice of inpatient authorization is mailed to the admitting facility. Providers can request additional copies of adverse determination letters by contacting Beacon.

Return of Inadequate or Incomplete Treatment Requests

All requests for authorization must be original and specific to the dates of service requested, and tailored to the Member's individual needs. Beacon reserves the right to reject or return authorization requests that are incomplete, lacking in specificity, or incorrectly filled out. Beacon will provide an explanation of action(s) which must be taken by the Provider to resubmit the request.

Notice of Inpatient/Diversionary Approval or Denial

Verbal notification of approval is provided at the time of preservice or continuing stay review. Notice of admission or continued stay approval is mailed to the Member or Member's guardian and the requesting facility within the time frames specified later in this chapter.

If the clinical information available does not support the requested level of care, the UR clinician discusses alternative levels of care that match the Member's presenting clinical symptomatology, with the requestor. If an alternative setting is agreed to by the requestor, the revised request is approved. If agreement cannot be reached between the Beacon UR clinician and the requestor, the UR clinician consults with a Beacon psychiatrist or psychologist advise (for outpatient services only). All denial decisions are made by a Beacon physician or psychologist (for outpatient services only) advise. The UR clinician and/or Beacon physician advisor offers the treating Provider the opportunity to seek reconsideration if the request for authorization is denied.

All Member notifications include instructions on how to access interpreter services, how to proceed if the notice requires translation or a copy in an alternate format, and toll-free telephone numbers for TDD/TTY capability, in established prevalent languages (Babel Card).

Termination of Outpatient Care

Beacon requires that all outpatient Providers set specific termination goals and discharge criteria for Members. Providers are encouraged to use the LOCC (accessible through eServices) to determine if the service meets Medical Necessity for continuing outpatient care.

Decision and Notification Timeframes

Beacon is required by the State and Federal governments to render utilization review decisions in a timely manner to accommodate the clinical urgency of a situation. Beacon has adopted the strictest time frame for all UM decisions in order to comply with the various requirements.

The time frames below present Beacon's internal time frames for rendering a UM determination, and notifying Members of such determination. All time frames begin at the time of Beacon's receipt of the request. Please note the maximum time frames may vary from those on the table below on a case-by-case basis in accordance with State and Federal government or requirements that have been established for each line of business.

TABLE 4-3: DECISION AND NOTIFICATION TIME FRAMES				
	Type of Decision	**Decision Time frame**	**Verbal notification**	**Written notification**
Preservice Review				
Initial Auth for Inpatient Behavioral Health Emergencies	Expedited	Within 30 minutes	Within 30 minutes	Within 24 hours
Initial Auth for Non-Emergent Inpatient Behavioral Health Services	Expedited	Within 2 hours	Within 2 hours	Within 24 hours
Initial Auth for Other Urgent Behavioral Health Services	Urgent	Within 72 hours	Within 72 hours	Within 72 hours
Initial Auth for Non-Urgent Behavioral Health Services	Standard	Within 10 calendar days	Within 10 calendar days	Within 10 calendar days
Concurrent Review				
Continued Auth for Inpatient and Other Urgent Behavioral Health Services	Urgent/ expedited	Within 24 hours	Within 24 hours	Within 3 calendar days
Continued Auth for Nonurgent Behavioral Health Services	Nonurgent/ standard	Within 10 calendar days	Within 10 calendar days	Within 10 calendar days
Post Service				
Authorization for Behavioral Health Services Already Rendered	Nonurgent/ standard	Within 10 calendar days	Within 10 calendar days	Within 10 calendar days

When the specified time frames for standard and expedited prior authorization requests expire before Beacon makes a decision, an adverse action notice will go out to the Member on the date the time frame expires.

Request for Reconsideration of Adverse Determination

If a Health Plan Member or Member's Provider disagrees with a utilization review decision issued by Beacon, the Member, his/her authorized representative, or the Provider may request reconsideration. Please call Beacon promptly upon receiving notice of the denial for which reconsideration is requested.

When reconsideration is requested, a PA will review the case based on the information available and will make a determination within one business day. If the Member, Member representative or Provider is not satisfied with the outcome of reconsideration, he or she may file an appeal.

5. Provider Appeals

Provider Appeals and Grievance Procedures

You have the right to file with Humana:

- A Medical Necessity Appeal
  Please refer to Humana's Appeals and Grievance Procedures for further information.

You have the right to file with Beacon:

- Contractual Appeals
- Administrative Appeals (i.e., claims appeals)
- Provider Grievances

How to Submit a Provider Appeal

Claims Appeals:
Providers can submit claims through our secure Provider Portal, or in writing

Provider Portal: www.beaconhs.com/Providers
Click on "tools" and enter the Health Plan name, and then click "Claims"

Writing: Use the "Provider Claim Appeal Request Form" located in this Manual or on our website.
Please include:

- The Member's name and Humana Member ID number
- The Provider's name and ID number
- The code(s) and reason why the determination should be reconsidered
- If you are submitting a Timely Filing appeal, you must send proof of original receipt of the appeal by fax or Electronic Data Information (EDI) for reconsideration
- If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification for reversing the determination

Mail: Beacon Health Options
Humana Claims Department
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393

Member Grievance, Appeals and Fair Hearing Requests

Members have the right to file a Grievance or appeal. They also have the right to request a State Hearing once they have exhausted their appeal rights. Please refer to Humana's Member Grievance and Appeals procedures for further information.

This chapter presents all information needed to submit claims to Beacon. Beacon strongly encourages Providers to rely on electronic submission, either through EDI or eServices in order to achieve the highest success rate of first-submission claims.

6. General Claim Policies

Beacon requires that Providers adhere to the following policies with regard to claims:

Definition of "Clean Claim"

A clean claim, as discussed in this Provider Manual Appendix, the Provider services agreement, and in other Beacon informational materials, is defined as one that has no defect and is complete including required substantiating documentation of particular circumstance(s) warranting special treatment without which timely payments on the claim would not be possible.

Electronic Billing Requirements

The required edits, minimum submission standards, signature certification form, authorizing agreement and certification form, and data specifications as outlined in this Manual must be fulfilled and maintained by all Providers and billing agencies submitting electronic media claims to Beacon.

Provider Responsibility

The individual Provider is ultimately responsible for accuracy and valid reporting of all claims submitted for payment. A Provider utilizing the services of a billing agency must ensure through legal contract (a copy of which must be made available to Beacon upon request) the responsibility of a billing service to report claim information as directed by the Provider in compliance with all policies stated by Beacon.

Limited Use of Information

All information supplied by Beacon or collected internally within the computing and accounting systems of a Provider or billing agency (e.g., Member files or statistical data) can be used only by the Provider in the accurate accounting of claims containing or referencing that information. Any redistributed or dissemination of that information by the Provider for any purpose other than the accurate accounting of behavioral health claims is considered an illegal use of confidential information.

Prohibition of Billing Members

Providers are not permitted to bill Health Plan Members under any circumstances for covered services rendered, excluding copayments when appropriate. See Chapter 1, Prohibition on Billing Members for more information.

Beacon's Right to Reject Claims

At any time, Beacon can return, reject or disallow any claim, group of claims, or submission received pending correction or explanation.

Recoupments and Adjustments by Beacon

Beacon reserves the right to recoup money from Providers due to errors in billing and/or payment, at any time. In that event, Beacon applies all recoupments and adjustments to future claims processed, and reports such recoupments and adjustments on the EOB with Beacon's Record Identification Number (REC.ID) and the Provider's patient account number.

Claim Turnaround Time

All clean claims will be adjudicated within thirty (30) days from the date on which Beacon receives the claim.

Claims for Inpatient Services:

- The date range on an inpatient claim for an entire admission (i.e., not an interim bill) must include the admission date through the discharge date. The discharge date is not a covered day of service but must be included as the "to" date. Refer to authorization notification for correct date ranges.
- Beacon accepts claims for interim billing that include the last day to be paid as well as the correct bill type and discharge status code. On bill type X13, where X represents the "type of facility" variable, the last date of service included on the claim will be paid and is not considered the discharge day.
- Providers must obtain authorization from Beacon for all ancillary medical services provided while a Health Plan Member is hospitalized for a behavioral health condition. Such authorized medical services are billed directly to the Health Plan.
- Beacon's contracted reimbursement for inpatient procedures reflect all-inclusive per diem rates.

Coding

When submitting claims through eServices, users will be prompted to include appropriate codes in order to complete the submission, and drop-down menus appear for most required codes. See EDI Transactions – 837 Companion Guide for placement of codes on the 837 file. Please note the following requirements with regard to coding.

- Providers are required to submit HIPAA-compliant coding on all claim submissions; this includes the appropriate HIPAA-compliant revenue, DSM, CPT, HCPCS and ICD codes. Providers should refer to exhibit A for a complete listing of contracted, reimbursable procedure codes.
- Beacon accepts only the appropriate ICD diagnosis codes listing approved by CMS and HIPAA. All diagnosis codes submitted on a claim form must be a complete diagnosis code with appropriate check digits.
- Claims for inpatient and institutional services must include the appropriate discharge status code and be billed in accordance with the National Uniform Billing Committee (NUBC) standards.

* All UB-04 claims must include the 3-digit bill type code and be billed in accordance with the National Uniform Billing Committee (NUBC) standards.

Modifiers

Modifiers can reflect the discipline and licensure status of the treating practitioner or are used to make up specific code sets that are applied to identify services for correct payment. Table 6-1 lists some HIPAA-compliant modifiers accepted by Beacon. Please see your Behavioral Health Services Agreement for Modifiers that are included in your contract.

TABLE 6-1: MODIFIERS

HIPAA Modifier	Modifier Description	HIPAA Modifier	Modifier Description
AH	Clinical psychologist	HR	Family/couple with client present
AJ	Clinical social worker	HS	Family/couple without client present
HB	Adult program, non-geriatric	HU	Funded by child welfare agency
HC	Adult program, geriatric	HW	Funded by State behavioral health agency
HD	Pregnant/parenting women's program	HX	Funded by county/local agency

HE	Behavioral health program	SA	Nurse Practitioner (This modifier required when billing 90862 performed by a nurse practitioner.)
HF	Substance use program	SE	State and/or Federally funded programs/services
HG	Opioid addiction treatment program	TD	Registered Nurse
HH	Integrated behavioral health/substance use program	TF	Intermediate level of care
HI	Integrated behavioral health and mental retardation/developmental disabilities program	TG	Complex/high level of care
HK	Specialized behavioral health programs for high-risk populations	TJ	Program group, child and/or adolescent
HM	Less than bachelor degree level	UK	Service provided on behalf of the client to someone other than the client-collateral relationship
HN	Bachelor's degree level	U3	Psychology intern
HO	Master's degree level	U4	Social work intern
HP	Doctoral level	U6	Psychiatrist (This modifier required when billing for 90862 provided by a psychiatrist.)
HQ	Group setting	UD	Substance Abuse Service

Time Limits for Filing Claims

Bacon Health Strategies must receive claims for covered services within the designated filing limit:

- Within 60 days of the dates of service on outpatient claims
- Within 60 days of the date of discharge on inpatient claims, or

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the 60-day filing limit will be denied unless submitted as a waiver or reconsideration request, as described in this chapter.

Coordination of Benefits (COB)

In accordance with The National Association of Insurance Commissioners (NAIC) regulations, Beacon Health Options coordinates benefits for behavioral health and substance use claims when it is determined that a person is covered by more than one Health Plan, including Medicare:

- When it is determined that Beacon Health Options is the secondary payer, claims must be submitted with a copy of the primary insurance's explanation of benefits report and received by Beacon within 60 days of the date on the EOB.
- Beacon Health Options reserves right of recovery for all claims in which a primary payment was made prior to receiving EOB information that deems Beacon the secondary payer. Beacon applies all recoupments and adjustments to future claims processed, and reports such recoupments and adjustments on the EOB.

7. Provider Education and Outreach

Summary

In an effort to help Providers that may be experiencing claims payment issues, Beacon runs quarterly reports identifying those Providers that may benefit from outreach and education. Providers with low approval rates are contacted and offered support and documentation material to assist in reconciliation of any billing issues that are having an adverse financial impact and ensure proper billing practices within Beacon's documented guidelines.

Beacon's goal in this outreach program is to assist Providers in as many ways as possible to receive payment in full, based upon contracted rates, for all services delivered to Members.

How the Program Works

- A quarterly approval report is generated that lists the percentage of claims paid in relation to the volume of claims submitted.
- All Providers below 75 percent approval rate have an additional report generated listing their most common denials and the percentage of claims they reflect.
- An outreach letter is sent to the Provider's billing director as well as a report indicating the top denial reasons. A contact name is given for any questions or to request further assistance or training.

Claim Inquiries and Resources

Additional information is available through the following resources:

Online at http://www.beaconhealthstrategies.com/providers.html

- Chapter 6 of this Manual
- Beacon's Claims Page
- Read About eServices
- eServices User Manual
- Read About EDI
- EDI Transactions – 837 Companion Guide
- EDI Transactions – 835 Companion Guide

Email Contact

- Provider.relations@beaconhs.com
- EDI.Operations@beaconhs.com

Telephone

- Interactive Voice Recognition (IVR): 1-888-210-2018

  You will need your practice or organization's tax ID, the Member's identification number and date of birth, and the date of service.
- Claims Hotline: 1-888-249-0478
  Hours of operation are 8:30 a.m. – 5:30 p.m., Monday – Thursday, 9 a.m. – 5 p.m. Friday

- Beacon's Main Telephone Numbers
  Provider Relations 1-855-481-7044
  EDI 1-855-481-7044
  TTY 1-855-539-5884
  FAX 1-855-371-9232

Electronic Media Options

Providers are expected to complete claim transactions electronically through one of the following, where applicable:

- Electronic Data Interchange (EDI) supports electronic submission of claim batches in HIPAA-compliant 837P format for professional services and 837I format for institutional services. Providers may submit claims using EDI/837 format directly to Beacon or through a billing intermediary. If using Emdeon as the billing intermediary, two identification numbers must be included in the 837 file for adjudication:
  - Beacon's payor ID is 43324; and
  - Beacon's Health Plan-specific ID045.
- eServices enables Providers to submit inpatient and outpatient claims without completing a CMS-1500 or UB-04 claim form. Because much of the required information is available in Beacon's database, most claim submissions take less than one minute and contain few, if any errors.
- IVR provides telephone access to Member eligibility, claim status and authorization status.

Claim Transaction Overview

Table 7-1 below, identifies all claim transactions, indicates which transactions are available on each of the electronic media, and provides other information necessary for electronic completion. Watch for updates as additional transactions become available on EDI, eServices and IVR.

TABLE 7-1: CLAIM TRANSACTION OVERVIEW

Transaction	Access on:			Applicable When:	Timeframe for Receipt by Beacon	Other Information
	EDI	eServices	IRV			
Member Eligibility Verification	Y	Y	Y	• Completing any claim transaction • Submitting clinical authorization requests	N/A	N/A
Submit Standard Claim	Y	Y	N	Submitting a claim for authorized, covered services, within the timely filing limit	Within 180 days after the date of service	N/A

Resubmission of Denied Claim	N	N	N	A claim being submitted for the first time will be received by Beacon after the original 180-day filing limit, and must include evidence that one of the following conditions is met: • Provider is eligible for reimbursement retroactively • Member was enrolled in the Health Plan retroactively • Services were authorized retroactively • Third party coverage is available and was billed first (A copy of the other insurance's explanation of benefits or payment is required.)	Within 180 days from the qualifying event	• Waiver requests will be considered only for these three circumstances. A waiver request that presents a reason not listed here, will result in a claim denial on a future EOB. • A claim submitted beyond the filing limit that does not meet the above criteria may be submitted as a reconsideration request. • Beacon's waiver determination is reflected on a future EOB with a message of Waiver Approved or Waiver Denied: if waiver of the filing limit is approved, the claim appears adjudicated; if the request is denied, the denial reason appears.
Request for Reconsideration of Timely Filing Limit*	Y	N	Y	Claim falls outside of all time frames and requirements for resubmission, waiver and adjustment	Within 180 days from the date of payment or nonpayment	Future EOB shows "Reconsideration Approved" or "Reconsideration Denied" with denial reason
Request to Void Payment	N	N	N	• Claim was paid to Provider in error • Provider needs to return the entire paid amount to Beacon	N/A	***Do NOT send a refund check to Beacon.***

Request for Adjustment (Corrected Claims)	Y	Y	N	• The amount paid to Provider on a claim was incorrect. • Adjustment may be requested to correct: o Underpayment (positive request) o Overpayment (negative request)	• Positive request must be received by Beacon within 180 days from the date of original payment. • No filing limit applies to negative requests.	• Do NOT send a refund check to Beacon • A Rec ID is required to indicate that the claim is an adjustment • Adjustments are reflected on a future EOB as recoupment of the previous (incorrect) amount and, if money is owed to the Provider, repayment of the claim at the correct amount. • If an adjustment appears on an EOB and is not correct, another adjustment request may be submitted based on the previous incorrect adjustment • Claims that have been denied cannot be adjusted, but may be resubmitted.
Obtain Claim Status	N	Y	Y	Available 24/7 for all claim transactions submitted by Provider.	N/A	Claim status is posted within 48 hours after receipt by Beacon.
View/Print Remittance Advice (RA)	N	Y	N	Available 24/7 for all claim transactions received by Beacon.	N/A	Printable RA is posted within 48 hours after receipt by Beacon.

**** Please note that waivers and reconsiderations apply only to the claims filing limit; claims are still processed using standard adjudication logic and all other billing and authorization requirements must be met. Accordingly, an approved waiver or reconsideration of the filing limit does not guarantee payment, since the claim could deny for another reason.***

Paper Claim Transactions

Providers are strongly discouraged from using paper claim transactions where electronic methods are available, and should be aware that processing and payment of paper claims is slower than that of electronically submitted claims. Electronic claim transactions take less time and have a higher rate of approval since most errors are eliminated.

For paper submissions, Providers are required to submit clean claims on the National Standard Format CMS-1500 or UB-04 claim form. No other forms are accepted.

Paper claim submission must be done using the most current form version as designated by the Centers for Medicare & Medicaid Services (CMS), National Uniform Claim Committee (NUCC). We cannot accept handwritten claims or SuperBills.

Detailed instructions for completing each form type are available at the websites below.

- CMS-1500 Form Instructions
  www.cms.hhs.gov/transmittals/downloads/R1104CP.pdf

- UB-04 Form Instructions: www.nucc.org

Mail paper claims to:
Beacon Health Options
Humana Claims Department
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393

Beacon does not accept claims transmitted by fax.

Paper Resubmission

Beacon Discourages Paper Transactions

BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS EARLIER IN THIS CHAPTER.

Paper submissions have more fields to enter, a higher error rate/lower approval rate, and slower payment.

- See Table 7-1 for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.
- If the resubmitted claim is received by Beacon more than 180 days from the date of service. The REC.ID from the denied claim line is required and may be provided in either of the following ways:
    - Enter the REC.ID in box 64 on the UB-04 claim form, or in box 19 on the CMS-1500 form.
    - Submit the corrected claim with a copy of the EOB for the corresponding date of service; or
- The REC.ID corresponds with a single claim line on the Beacon EOB. Therefore, if a claim has multiple lines there will be multiple REC.ID numbers on the Beacon EOB.
- The entire claim that includes the denied claim line(s) may be resubmitted regardless of the number of claim lines; Beacon does not require one line per claim form for resubmission. When resubmitting a multiple-line claim, it is best to attach a copy of the corresponding EOB.
- Resubmitted claims cannot contain original (new) claim lines along with resubmitted claim lines.
- Resubmissions must be received by Beacon within 180 days after the date on the EOB. A claim package postmarked on the 180th day is not valid.
- If the resubmitted claim is received by Beacon within 180 days from the date of service, the corrected claim may be resubmitted as an original. A corrected and legible photocopy is also acceptable.

Paper Submission of 180-day Waiver

- See Table 7-1 for an explanation of waivers, when a waiver request is applicable, and procedural guidelines;
- Watch for notice of waiver requests becoming available on eServices.
- Download the 180-day waiver form.
- Complete a 180-day waiver form for each claim that includes the denied claim(s), per the instructions below;
- Attach any supporting documentation;
- Prepare the claim as an original submission with all required elements;
- Send the form, all supporting documentation, claim and brief cover letter to:
  Beacon Health Options
  Claim Department/Waivers
  500 Unicorn Park Drive, Suite 401
  Woburn, MA 01801-3393

Completion of the Waiver Request Form

To ensure proper resolution of your request, complete the 180-day waiver request form as accurately and legibly as possible.

1. **Provider Name**
   Enter the name of the Provider who provided the service(s).
2. **Provider ID Number**
   Enter the Provider ID Number of the Provider who provided the service(s).
3. **Member Name**
   Enter the Member's name.
4. **Health Plan Member ID Number**
   Enter the Plan Member ID Number.
5. **Contact Person**
   Enter the name of the person whom Beacon should contact if there are any questions regarding this request.
6. **Telephone Number**
   Enter the telephone number of the contact person.
7. **Reason for Waiver**
   Place an "X" on all the line(s) that describe why the waiver is requested.
8. **Provider Signature**
   A 180-day waiver request cannot be processed without a typed, signed, stamped, or computer-generated signature. Beacon will not accept "Signature on file."
9. **Date**
   Indicate the date that the form was signed.

Paper Request for Adjustment or Void

Beacon Discourages Paper Transactions

BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS EARLIER IN THIS CHAPTER.

Paper submissions have more fields to enter, a higher error rate/lower approval rate, and slower payment.

- See Table 7-1 for an explanation of adjustments and voids, when these requests are applicable, and procedural guidelines;
- **Do not send a refund check to Beacon.** A Provider who has been incorrectly paid by Beacon must request an adjustment or void;
- Prepare a new claim as you would like your final payment to be, with all required elements; place the Rec.ID in box 19 of the CMS-1500 claim form, or box 64 of the UB04 form or;
- Download and complete the Adjustment/Void Request Form per the instructions below;
- Attach a copy of the original claim;
- Attach a copy of the EOB on which the claim was paid in error or paid an incorrect amount;

Send the form, documentation and claim to:
Beacon Health Options
Claim Departments – Adjustment Requests
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393

To Complete the Adjustment/Void Request Form

To ensure proper resolution of your request, complete the Adjustment/Void Request form as accurately and legibly as possible and include the attachments specified above.

1. **Provider Name**
   Enter the name of the Provider to whom the payment was made.

2. **Provider ID Number**
   Enter the Beacon Provider ID Number of the Provider that was paid for the service. If the claim was paid under an incorrect Provider number, the claim must be voided and a new claim must be submitted with the correct Provider ID Number.

3. **Member Name**
   Enter the Member's name as it appears on the EOB. If the payment was made for the wrong Member, the claim must be voided and a new claim must be submitted.

4. **Member Identification Number**
   Enter the Plan Member ID Number as it appears on the EOB. If a payment was made for the wrong Member, the claim must be voided and a new claim must be submitted.

5. **Beacon Record ID number**
   Enter the record ID number as listed on the EOB.

6. **Beacon Paid Date**
   Enter the date the check was cut as listed on the EOB.

7. **Check Appropriate Line**
   Place an "X" on the line that best describes the type of adjustment/void being requested.

8. **Check All that Apply**
   Place an "X" on the line(s) which best describe the reason(s) for requesting the adjustment/void. If "Other" is marked, describe the reason for the request.

9. **Provider Signature**
   An adjustment/void request cannot be processed without a typed, signed, stamped, or computer-generated signature. Beacon will not accept "Signature on file".

10. **Date**
    List the date that the form is signed.

8. Provider Education of Compliance-based Materials

Providers are expected to adhere to all training programs identified as compliance-based training by Humana and Beacon. This includes agreement and assurance that all affiliated Participating Providers and staff members are trained on the identified compliance material. This includes the following training modules:

- Provider Orientation
- Medicaid Provider Orientation
- Cultural Competency (required annually)
- Health, Safety and Welfare Education (required annually)
- Fraud, Waste and Abuse Detection, Correction and Prevention (required annually)

For information on Humana's Cultural Competency Plan, see Section I – General Provider Information, subsection 12.

For information on Humana's Health, Safety, and Welfare Training, see Section I – General Provider Information, subsection 15.

For information on Humana's Fraud, Waste, and Abuse Training, see Section I – General Provider Information, subsection 14.

Additional information on these topics is included in Humana's required annual compliance training as identified by Humana and Beacon. Please contact Beacon Provider Relations at 1-855-481-7044 or visit us at https://www.beaconhs.com/providers and click on "Tools" for help in understanding how to access this required training.

ATTACHMENT A: AUTHORIZATION GUIDELINES

Outpatient

Benefit/Service	**Authorization Requirement**	
Medication Management (E/M)	None	
Psychiatric Diagnostic Interview with Medical Services	None	
Psychiatric Diagnostic Evaluation	None	
Injection Administration	None	
Mental Health/SA Assessment	None	
Treatment Plan Development	None	
Group Therapy	None	
Prenatal Care At-Risk Assessment	None	
Individual Psychotherapy	None	Care Plan update required after two sessions <60 days, where applicable
Crisis Intervention	None	
Family and Marital Therapy	None	
Medication Administration	None	
Mental Health Risk Assessment	None	
Case Consultation	None	
Therapy with Biofeedback or Hypnosis	None	

Psychological Testing	Prior authorization required	
Neuropsychological Testing		
ECT		
Inpatient Services		
Benefit/Service	**Authorization Requirement**	**Other Requirements**
Inpatient Hospitalization	Telephonic prior authorization	Telephonic continued stay required.
Crisis Stabilization	Telephonic Authorization (After 72 hours)	
Observation	Telephonic Authorization (After 72 hours)	
Emergency Room Services	None	