# Virginia Commonwealth Coordinated Care ("Demonstration") Appendix

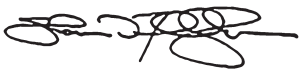
## Welcome

Thank you for your participation with Humana, where our goal is to provide quality services to Virginia's Demonstration Members.

This Provider Manual Appendix ("Appendix") is an extension of, and supplement to, Humana's Provider Manual for Physicians, Hospitals and Healthcare Providers. The Appendix highlights the key points related to Humana's Virginia Demonstration 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 Virginia Demonstration program is about, what we need from you, and what you can expect from Humana. 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, a Commonwealth Coordinated Care plan.

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,



Shawn D. Gallagher
Vice President, Mid-Atlantic Region Humana

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# Table of contents

## SECTION I – GENERAL PROVIDER INFORMATION



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# Table of contents – continued

## SECTION I – GENERAL PROVIDER INFORMATION — continued



## SECTION II – LONG–TERM SERVICES AND SUPPORTS



Humana®

# Table of contents – continued

## SECTION II – LONG–TERM SERVICES AND SUPPORTS — continued



## SECTION III – BEHAVIORAL HEALTH



Humana®

# Table of contents – continued

## SECTION III – BEHAVIORAL HEALTH — continued



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# SECTION I – GENERAL PROVIDER INFORMATION

## 1. Program Description

Virginia's Commonwealth Coordinated Care (CCC) program (Demonstration) provides health care coverage for Humana's Members who are dually eligible for both Medicare and Medicaid and who are enrolled in the Demonstration. The Demonstration represents a three-way contract between and among the Commonwealth of Virginia (State), Center for Medicare & Medicaid Services (CMS) and Humana. The Virginia Department of Medical Assistance Services (DMAS or "Agency") will administer contracts, monitor Health Plan performance, and provide oversight in all aspects of Health Plan operations.

CMS and the State have sole authority for determining eligibility for the Demonstration. The State will contract with an enrollment broker/facilitator for assistance in administering the Demonstration and meeting enrollee (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 DMAS to facilitate education, enrollment, and outreach endeavors, and serve as a key customer service component for Demonstration Members.

The Demonstration is expected to transform the Dual-eligible program by empowering Dual–eligible recipients to take control of their health care, 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 Members, Humana has agreed to comply with the provisions of the Demonstration Contract ("Contract") as well as with all applicable Agency rules relating to the Contract and the applicable rules that may be implemented by the State to regulate the administration of the Demonstration.

**Note:** Providers will receive at least thirty (30) days advance notice in writing of policy and procedure changes and will be provided education and training for any changes that are to be implemented prior to the policy and/or procedure changes taking effect.

**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. To review Humana's Provider Manual for Physicians, Hospitals and Healthcare Providers, please visit **Humana.com/provider/support/publications/**.

### 1.1 Definitions

**The following are definitions specific to this Appendix:**

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

**Agency:** Virginia Department of Medical Assistance Services (DMAS)

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

**Benefits:** A schedule of health care services to be delivered to a Member covered by the Health Plan.

**Complaint:** Any oral or written expression of dissatisfaction by a Member submitted to the Health Plan or to a State agency. 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 or 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.

**Consumer–directed (CD) model of services:** The model of service delivery for which the waiver Enrollee or the Enrollee'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 DMAS.

**Contract(s):** The Contract between U.S. DHHS Centers for Medicare & Medicaid Services in partnership with the State of Virginia and Humana for the Demonstration.

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

**Dual-eligible Recipient:** Any individual whom the State and CMS determines is eligible, pursuant to federal and State law, to receive medical or allied care, goods or services for which the Agency and CMS may make payments under the Demonstration program, and who is enrolled in the Demonstration program.

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

**Emergency Medical Condition:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (1) that there is inadequate time to affect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

**Emergency Services:** Inpatient and outpatient services covered under this Contract that are furnished by a Provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.

**Enrollee:** See "Member" below.

**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 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.

**Health Plan:** An entity that integrates financing and management with the delivery of health care 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 also has contracted with the Agency to provide Demonstration services and includes health maintenance organizations authorized under applicable Virginia law and regulations.

**Home and Community–based Services (HCBS) Waiver:** A variety of Medicaid home and community–based services as authorized under a §1915(c) waiver designed to offer an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid institutionalization (NF) placement.

**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 CCC 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 thereunder, as administered in the State by the Agency.

**Member:** A Demonstration recipient currently enrolled in the Health Plan.

**Medicaid Dual–eligible Reform:** Reforms resulting from the Feb. 22, 2013, approval the Agency received from CMS to jointly implement the CCC.

**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 media.

**Medically Necessary or Medical Necessity:** Per Medicare, services must be 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. Per Virginia Medicaid, an item or service provided for the diagnosis or treatment of an Enrollee's condition consistent with standards of medical practice and in accordance with Medicaid policy (12 VAC 30-130-600). Furthermore, as defined in 42 C.F.R. § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose. Services must be provided in a way that provides all protections to covered individuals provided by Medicare and Virginia Medicaid.

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

**Newborn:** A live child born to a Member, who is a Member of 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 Provider (or Network Provider):** A health care Provider who is contracted under a currently valid provider agreement to participate in a Health Plan's CCC, Medicare Advantage and/or Medicaid networks serving Demonstration Members.

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

**Patient-centered Medical Home:** A health care 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 exchanges and other means to ensure 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 and 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, Members with chronic health conditions, disabilities or special health care 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.

**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 ensuring that the delivery of health care services are available, accessible, timely, medically necessary and provided in sufficient quantity, of acceptable quality, within established standards of excellence and appropriate for meeting the needs of the Members.

**Quality Improvement Program (QIP):** The process of ensuring the delivery of health care 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:** Commonwealth of Virginia.

**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-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 substantially restrict a Member's activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

**Virginia Department of Health:** The State agency that oversees public health throughout the Commonwealth of Virginia.

**Well-care Visit:** A routine medical visit for one of the following: 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 Health Plan, through its contracted Providers, is required to arrange for Medically Necessary services for each Member. In providing Covered Services to Demonstration Members, the Provider is required to adhere to applicable provisions in the State Demonstration coverage, as well all State and federal laws pertaining to the provision of such services. The Plan covers Medicare Part A, Part B, Part D and Medicaid-covered services. All benefit limits for Medicaid-covered services should be verified through Humana or DMAS (12 VAC 30-50) and the appropriate DMAS provider manual. The Member benefit summary will be supplemented once available.

Please see www.virginiamedicaid.dmas.virginia.gov/wps/portal/providermanual.

## 2.2 Out-of-network care for services not available

Humana will arrange for out-of-network care if it is unable to provide Members with necessary Covered Services, or a second opinion if a network Provider is not available.

## 2.3 Expanded services

Expanded services are those services offered by Humana and approved in writing by the Agency. These services are in excess of the amount, duration and scope of those services listed above. Such services are outlined in the benefit summaries. For additional information, Providers can call the customer service number provided on the back of the Member's ID card.

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

## 2.4 Specific UM Processes for Skilled Nursing Facilities

Humana and Provider Nursing Facilities' Pre-Authorization/Authorization Process Considerations:

- There is no three-day qualifying stay requirement for a skilled nursing facility admission
- Prior authorization is required
- When medical necessity is met, Humana will provide an initial seven-day authorization period
- Humana Utilization Management (UM) and the SNF will begin to work collaboratively on the case during that seven-day period for discharge planning
- Following the initial seven-day authorization period, continued stay review will be conducted based on medical necessity.

## 2.5 Member Summary of Benefits

| Health need or problem | Services Members may need | Member costs for in-network providers | Limitations, exceptions and benefit information (rules about benefits) |
|---|---|---|---|
| Member wants to see a doctor | Visits to treat an injury or illness | $0 copay | Prior authorization and referral may be required. |
| | Wellness visits, such as a physical | $0 copay | |
| | Transportation to a doctor's office | $0 copay | Reservations are required for non-emergent transportation. |
| | Specialist care | $0 copay | Prior authorization and/or referral may be required. |

## 2.5 Member Summary of Benefits

| Health need or problem | Services Members may need | Member costs for in-network providers | Limitations, exceptions and benefit information (rules about benefits) |
|---|---|---|---|
| Member wants to see a doctor | Care to keep Members from getting sick, such as flu shots | $0 copay | |
| | "Welcome to Medicare" preventive visit (one time only) | $0 copay | |
| Member needs medical tests | Lab tests, such as blood work | $0 copay | Prior authorization and/or referral may be required. |
| | X-rays or other pictures, such as CAT scans | $0 copay | Prior authorization and/or referral may be required. |
| | Screening tests, such as tests to check for cancer | $0 copay | Prior authorization and/or referral may be required. |
| Member needs drugs to treat his/her illness or condition<br><br>There may be limitations on the types of drugs covered. Please see Humana Gold Plus Integrated's List of Covered Drugs (Drug List) for more information. | Generic drugs (no brand name) | **For a 30-day supply:**<br>• A $0 copay; or up to<br>• A $3.30 copay<br>**For a 90-day supply:**<br>• A $0 copay; or up to<br>• A $9.90 copay<br>Copays for prescription drugs may vary based on the level of Extra Help the Member receives. Please contact the plan for more details. | Not all drugs are available for an extended day supply. Please contact the plan for more information. Prior authorization may be required. |
| | Brand name drugs | **For a 30-day supply:**<br>• A $0 copay; or up to<br>• A $8.25 copay<br>**For a 90-day supply:**<br>• A $0 copay; or up to<br>• A $24.75 copay<br>Copays for prescription drugs may vary based on the level of Extra Help the Member receives. Please contact the plan for more details. | Not all drugs are available for an extended day supply. Please contact the plan for more information. Prior authorization may be required. |
| Member needs drugs to treat his/her illness or condition<br><br>There may be limitations on the types of drugs covered. Please see Humana Gold Plus Integrated's List of Covered Drugs (Drug List) for more information. | Over-the-counter (OTC) drugs | $0 copay | Humana Gold Plus Integrated covers some Medicaid-covered OTC drugs when they are written as prescriptions by Provider.<br>Up to a $25 maximum allowance per month for certain non-Medicaid-covered OTC items. |

| Health need or problem | Services Members may need | Member costs for in-network providers | Limitations, exceptions and benefit information (rules about benefits) |
|---|---|---|---|
| Member needs drugs to treat his/her illness or condition<br><br>There may be limitations on the types of drugs covered. Please see Humana Gold Plus Integrated's List of Covered Drugs (Drug List) for more information. | Medicare Part B prescription drugs covered by Humana Gold Plus Integrated.<br>Part B drugs include drugs given in office, some oral cancer drugs, and some drugs used with certain medical equipment. | $0 copay | Prior authorization may be required. |
| Member needs therapy after a stroke or accident | Occupational, physical or speech therapy | $0 copay | Prior authorization and/or referral may be required. |
| Member needs emergency care | Emergency room services | $0 copay | Member may go to any emergency room if Member reasonably believes there is a need for emergency care. Prior authorization is not required. |
| | Ambulance services | $0 copay | |
| | Urgent care | $0 copay | Member may go to any urgent care facility.<br>Prior authorization is not required. |
| Member needs hospital care | Hospital stay | $0 copay | Prior authorization and/or referral may be required. |
| | Doctor or surgeon care | $0 copay | Prior authorization and/or referral may be required. |
| Member needs help getting better or has special health needs | Rehabilitation services | $0 copay | Prior authorization and/or referral may be required. |
| | Medical equipment for home care | $0 copay | Prior authorization and/or referral may be required. |
| | Skilled nursing care | $0 copay | Prior authorization and/or referral may be required. |
| Member needs eye care | Eye exams | $0 copay | Medicare-covered diagnosis and treatment for diseases and conditions of the eye, including an annual glaucoma screening for people at risk.<br>• Routine eye exam, which includes refraction, up to 1 per year |
| | Glasses or contact lenses | $0 copay | • 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery.<br>• 1 pair of medically necessary eye glasses (lenses and frames) per year<br>• 1 pair of contact lenses per year<br>• $100 maximum benefit coverage amount per year for contact lenses, eye glasses - lenses and frames. |

| Health need or problem | Services Members may need | Member costs for in-network providers | Limitations, exceptions and benefit information (rules about benefits) |
|---|---|---|---|
| Member needs dental care | Dental checkups | $0 copay | Plan covers Medicare and Medicaid dental services.<br>Plans offers additional services:<br>• 1 comprehensive oral evaluation per year<br>• 1 prophylaxis (cleaning) per year<br>• 1 filling (amalgam or composite) per year<br>• 1 set bite wing X-rays per year<br>• 1 panoramic X-ray per 3 years<br>Refer to Chapter 4 of the Member Handbook for more information on dental benefits. |
| Member needs hearing/ auditory services | Hearing screenings | $0 copay | • 1 fitting/evaluation per year<br>• 1 routine hearing test per year |
| | Hearing aids | $0 copay | $1,000 maximum benefit coverage amount for one hearing aid every three years.<br>• 1 hearing aid per ear every three years<br>• 16 Hearing aid batteries every year<br>• Hearing aid fitting, unlimited visits |
| Member has a chronic condition, such as diabetes or heart disease | Services to help manage Member's disease | $0 copay | Prior authorization and/or referral may be required. |
| | Diabetes supplies and services | $0 copay | Prior authorization and/or referral may be required. |
| Member has a mental health condition | Mental or behavioral health services | $0 copay | Prior authorization and/or referral may be required. |
| Member has a substance abuse problem | Substance abuse services | $0 copay | Prior authorization and/or referral may be required. |
| Member needs long-term mental health services | Inpatient care for people who need mental health care | $0 copay | Prior authorization and/or referral may be required. |
| Member needs durable medical equipment (DME) | Wheelchairs | $0 copay | Prior authorization may be required. |
| | Canes | $0 copay | Prior authorization may be required. |
| | Crutches | $0 copay | Prior authorization may be required. |
| | Walkers | $0 copay | Prior authorization may be required. |
| | Oxygen | $0 copay | Prior authorization may be required. |

| Health need or problem | Services Members may need | Member costs for in-network providers | Limitations, exceptions and benefit information (rules about benefits) |
|---|---|---|---|
| Member needs help living at home | Personal care assistant who may do tasks such as shopping, housekeeping and meal preparation (Member may be able to employ his/her own assistant. Call Customer Care for more information.) | $0 copay* | Prior authorization and/or referral may be required.<br>Waiver may be required. |
| | Home health care services | $0 copay | Prior authorization and/or referral may be required. |
| | Adult day services or other support services | $0 copay* | Prior authorization and/or referral may be required.<br>Waiver may be required. |
| | Transition services | $0 copay | Prior authorization and/or referral may be required.<br>Waiver may be required. |
| | Transition coordination | $0 copay | Prior authorization and/or referral may be required.<br>Waiver may be required. |
| Member need a place to live with people available to help him/her | Nursing facility care | $0 copay* | Prior authorization and/or referral may be required.<br>Waiver may be required. |
| Member caregiver needs some time off | Respite care | $0 copay* | Prior authorization and/or referral may be required.<br>May receive up to 480 hours per year.<br>Waiver may be required. |
| Member needs non-emergency transportation | Transportation to plan approved locations. | $0 copay | Reservations are required for non-emergency transportation. |
| Member has a non-emergency health question | Nurse hotline 24/7 | $0 copay | |

Long Term Services and Support must meet criteria set by DMAS or State

*The Member must contribute toward the cost of this service when Member's income exceeds an allowable amount. This contribution, known as the patient pay amount, is required if the Member lives in a nursing facility or receive services through the Elderly or Disabled with Consumer Direction (EDCD) Waiver.

## Other services that Humana Gold Plus Integrated covers

This is not a complete list. Call Customer Care to find out about other covered services (also outlined in the Member Handbook).

| Other services covered by Humana Gold Plus Integrated, A Commonwealth Coordinated Care | Member costs for in-network Providers |
|---|---|
| Health and wellness education programs | $0 copay |
| Pregnancy education | $0 copay |
| Fitness program | $0 copay |

## Other services that Humana Gold Plus Integrated covers — continued

| Other services covered by Humana Gold Plus Integrated, A Commonwealth Coordinated Care | Member costs for in-network Providers |
|---|---|
| Tobacco | $0 copay |
| Pregnancy | $0 copay |
| Compliance packaging* | $0 copay |
| Pest control | $0 copay waiver may be required.<br>Prior authorization may be required. |
| Post–discharge meals | $0 copay |

* Limited to enrollees who meet certain disability requirements.
** The Member must contribute toward the cost of this service when Member's income exceeds an allowable amount. This contribution, known as the patient pay amount, is required if the Member lives in a nursing facility or receives services through the Elderly or Disabled with Consumer Direction (EDCD) Waiver.

## Value added discounts — complementary and alternative medicine discount program

Complementary and alternative medicine (CAM) services include chiropractic, acupuncture and massage. Humana Members can obtain these services at a discount through the Healthways WholeHealth Network (HWHN). This network has more than 35,000 practitioners.

| Discounts include: | Additional information |
|---|---|
| Acupuncture | A trained professional uses very thin needles on different parts of the body. Needles are put just deep enough into the skin to keep them from falling out and are usually left in place for a few minutes. Acupuncture can be used to treat conditions such as pain, stomach problems, headaches and more. |
| Massage | A massage therapist uses hands and fingers to rub, press and move skin and muscles. A massage can relax and energize, and help heal muscles after an injury. |
| Chiropractic | A chiropractor checks for problems in the spine and fixes them by using hands to adjust the spine, joints and muscles. |

### How the discount works

Members don't need a referral to visit a practitioner in the HWHN network. Members may see HWHN providers as often as they like — but Members should talk with their primary care doctor about any treatment they are thinking about getting. If the Member is already seeing CAM professionals who are not on the HWHN list, the Member can ask to have them added to the network.

For the Member to receive the discount, he/she must show the Provider the discount card, which can be printed from **Humana.com**, or the Member can show the Provider his/her Humana member ID card.

### Contact information

For details about the program, go to the CAM website from **Humana.com**. Once you sign in to MyHumana, go to:

- Health & Wellness
- SavingsCenter, then select "Alternative Medicine"
- Scroll down to the middle part of the screen and click the link "Find an alternative medicine provider"

To find a provider, visit the HWHN website at **humana.wholehealthmd.com** or call **1-866-430-8647**, Monday – Friday, 8:30 a.m. – 8 p.m., Eastern time. For **TTY**, call **711**, Monday – Friday, 8:30 a.m. – 8 p.m., Eastern time.

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## Prescription medicine discount

Certain prescription medicines are not covered by Medicare prescription drug plans. Humana Members can get discounts on some prescription medicines that they obtain from the drug store. Use this discount for prescriptions Medicare won't pay for.

### How the discount works

Humana Members must show their ID card at participating pharmacies when they buy non-covered prescription medicines. Depending on the medicine purchased, quantity limits may apply. Most pharmacy chains and many independent pharmacies will give Members a discount. Discounts can vary greatly, and Members can check with their pharmacy to ensure they are getting the best available discount.

### Contact information

To find out if a Member will receive a pharmacy discount, call Customer Care using the number on the back of the Humana member ID card. For **TTY**, call **711**. We're available Monday – Friday, 8 a.m. – 8 p.m., Eastern time. However, please note that our automated phone system may answer the call after hours, during weekends and holidays. Please leave your name and telephone number, and we will call you back by the end of the next business day. Visit **Humana.com** for 24-hour access to information like claims history, eligibility and Humana's Drug List. There you can also use the physician finder and get health news and information.

## Services that Humana Gold Plus Integrated does not cover

This is not a complete list. Call Customer Care or read the Member Handbook to find out about other covered services.

| Services not covered by Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan | Additional information |
|---|---|
| Acupuncture and Other Alternative Therapies | Humana Members can obtain these services at a discount through the Healthways WholeHealth Network. This plan does not cover acupuncture and other alternative therapies. |
| Case Management Services for Participants of Auxiliary Grants | An income supplement for individuals who receive Supplemental Security Income (SSI) and certain other aged, blind, or disabled individuals who reside in a licensed assisted living facility (ALF) or an approved adult foster care (AFC) home. |

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

## Benefits covered outside of Humana Gold Plus Integrated

This is not a complete list. Call Customer Care to find out about other services not covered by Humana Gold Plus Integrated but available through Medicare or Medicaid.

| Services not covered by Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan | Additional Information |
|---|---|
| Targeted Case Management Services | Includes both referral/transition management and clinical services such as monitoring, self-management support, medication review and adjustment for Enrollees with developmental disabilities. |
| Certain Dental Services unless otherwise noted | Humana Gold Plus Integrated is responsible for some medically necessary procedures. Call Customer Care for more information. |
| Case Management Services for Participants of Auxiliary Grants | An income supplement for individuals who receive Supplemental Security Income (SSI) and certain other aged, blind, or disabled individuals who reside in a licensed assisted living facility (ALF) or an approved adult foster care (AFC) home. |

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# 3. Emergency service responsibility

Participating Providers are required to ensure adequate accessibility for health care 24 hours per day, seven days per week. An after-hours telephone number must be available to Members (voicemail is not permitted). Members should call their PCP first if they have an emergency, but go to the closest emergency room or any other emergency setting if they have an emergency 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

Providers must notify the Member's PCP, when applicable, of the Member's Emergent/Urgent screening or treatment.

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 receive 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 Behavioral Health Services

For behavioral health services, please instruct Members to contact Humana at **1-855-235-8579** and select Behavioral Health Crisis when prompted.

For emergency behavioral health care 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 their PCP 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 and Demonstration Care Coordination:

Humana's CCC 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, psychosocial and long-term services and support. This approach is aimed at eliminating fragmented and often poorly coordinated health care and social services that historically plagues the effective treatment for these individuals and results 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 in person, when applicable.
- Participation in inbound and outbound communications to promote 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

**New Members of the CCC are allowed to maintain:**

- Current Providers (including out-of-network Providers) for 180 days from enrollment.
- Preauthorized services as provided through DMAS transition reports, DMAS' contracted managed care entities, and Medicare for the duration of the prior authorization, or for 180 days from enrollment (whichever is sooner), except for individuals residing in a nursing facility at the date of Enrollment into the Demonstration. Individuals in nursing facilities at the time of Enrollment may remain in the facility as long as they continue to meet DMAS criteria for nursing home care, unless they or their families prefer to move to a different facility or return to the community.

**Members transferring from another Health Plan must be allowed to maintain:**

- Current Providers (including out-of-network providers) for 30 days from enrollment.
- Preauthorized services as provided through DMAS transition reports, DMAS' contracted managed care entities, and Medicare for the duration of the prior authorization or for 30 days from Enrollment (whichever is sooner), except for individuals residing in a nursing facility at the date of enrollment into the Health Plan. Individuals in nursing facilities at the time of Enrollment may remain in the facility as long as they continue to meet DMAS criteria for nursing home care, unless they or their families prefer to move to a different facility or return to the community.

## 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.
- Ensure that Members are informed of specific health care 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 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.
- Track and document appointments, clinical findings, treatment plans and care received by Members referred to specialists, other health care Providers or agencies to ensure continuity of care.
- Obtain authorizations for any out-of-network referrals when an in-network Provider of the specialty in question is not available in the geographical area.
- 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 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.

**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 30 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 DMAS 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/her authorized caregiver
- The Member's physicians and/or nurses
- Humana's clinical 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 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 health care 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
- Appropriate advanced illness and end-of-life planning

Virginia law allows for the following two types of advance directives: (1) health care power of attorney; and (2) written advance health care directive (also known as a living will). Providers should ensure that Members are informed of these rights. Further, any adult capable of making an informed decision who has been diagnosed by his attending physician as having a terminal condition may make an oral advance directive (i) directing the specific health care the declarant does or does not authorize in the event the declarant is incapable of making an informed decision, and (ii) appointing an agent to make health care decisions for the declarant under the circumstances stated in the advance directive if the declarant should be determined to be incapable of making an informed decision. An oral advance directive shall be made in the presence of the attending physician and two witnesses.

Forms and documentation regarding advanced directives can be downloaded from www.vsb.org/site/public/healthcare-decisions-day.

**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 Department of Social Services (LDSS) and law enforcement agency by telephone and submit a follow-up written report to LDSS and 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 Members With a Behavioral 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 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 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 adopt relevant, evidence-based medical and behavioral health guidelines (preventive and certain non-preventive 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 LTSS Medicaid benefits:**

- 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 ensure that these needs are adequately met and reduce the reliance on less appropriate and more costly emergency or hospital-based care.
- Preauthorization and referrals are a direct outcome of the Individualized Care Plan as developed by the ICT. Medical Providers should follow the preauthorization and referral section of Humana Provider Manual for Physicians, Hospitals and Healthcare Providers. LTSS and BH Providers should refer to the LTSS and BH sections for more detail.
- Demonstration Members are faced daily with a variety of life challenges. Humana aims to eliminate the challenges and frustration of navigating a complex health care system by integrating a variety of administrative processes for Members and Providers.

**Note:** Humana will perform at least annual reviews to ensure that Providers and any downstream, and/or related entities (as defined by the CCC) are qualified to perform the services covered. Humana will report to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a Provider's license.

# 5. Provider complaints

For all inquiries, including Complaints, please contact Humana Customer Care 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 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 office.

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## Filing a Grievance or an Appeal

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

If you are not happy with the answer you get from Customer Care, you can file a Grievance/Appeal. You can obtain a form or you can send a letter to Humana. If you request a form from Humana, it will be mailed within three working days. You can also request help from Humana to fill out the form. Note: Internal Appeals must first be exhausted before additional actions can be taken.

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

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

The Grievance/Appeal must have the following:

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

**Grievance:** You have the right to make a written or verbal Grievance within 60 days after the incident .

The Grievance process may take up to 30 days. However, Humana will resolve your Grievance as quickly as your health condition requires. A letter telling you the outcome of your Grievance will go out within 30 days from the date Humana receives your request. If more time is needed, you and Humana must agree on it. If other information is needed, Humana will have 14 extra days to make a decision. Humana will send you a letter telling you about the extra time.

**Appeal:** You have the right to make a written or verbal Appeal. You have up to sixty (60) calendar days from the date on the notice of adverse action, unless you, the member, can demonstrate good cause. The Appeals process may take up to 30 days. However, Humana will resolve your Appeal as quickly as your health condition requires. A letter telling you the outcome of your Appeal will go out within 30 days from the date Humana receives your request. If more time is needed, you and Humana must agree on it. If other information is needed, Humana will have 14 extra days to make a decision. Humana will send you a letter telling you about the extra time.

**Expedited Process:** You have the right to make an expedited verbal or written Grievance or Appeal. If you have a problem that is putting your life or health in danger, you or youtr legal spokesperson can file an “urgent” or “expedited” Appeal. These appeals are handled within 72 hours. Let the person you are talking to know that this is an “urgent” or “expedited” Appeal. You may request an expedited Appeal by calling Humana at **1-800-867-6601**. If it is determined that it is not an expedited process, it will go through the normal process.

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

Humana
Attn: Grievance & Appeal Analyst
P.O. Box 14546
Lexington, KY 40512-4546
Expedited Fax Line: **1-855-336-6220**
Standard Appeals Fax Line: **1-888-556-2128**

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

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

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

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

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

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

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

**Medicaid State Fair Hearing process**

If the Contractor's internal Appeal decision is not fully in the Enrollee's favor, the Enrollee may Appeal to the DMAS Appeals Division for Medicaid-based adverse decisions. Such Appeals must be made in writing and may be made via U.S. Mail, fax transmission, hand-delivery or electronic transmission. Appeals to the external Medicaid State Fair Hearing process will not be automatically forwarded to DMAS by the Contractor. Enrollees have the option of filing an expedited Appeal by telephone.

Parties to the State Fair Hearing include the Contractor as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate.

Appeals to the external Medicaid State Fair Hearing process must be filed within sixty (60) days of the date of the Contractor 's internal Appeal decision, unless the time period is extended by DMAS upon a finding of "good cause" in accordance with current State Fair Hearing regulations. See Section 2.14.1.7.3 and 2.14.1.7.4 for timeframes for issuing standard and expedited external Medicaid Appeal decisions.

If the DMAS Appeals Division decides in the Enrollee's favor and reverses the Contractor's decision, the Contractor must authorize the service under dispute as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date the Contractor receives the notice reversing the decision.

If the Enrollee disagrees with the DMAS Appeals Division's decision, further levels of Appeal are available, including an Appeal to the Circuit Court. There is then an automatic right to Appeal to the Virginia Court of Appeals. The next level of court review is to the Virginia Supreme Court.

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

# 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 hyperlipoproteinemia 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 determination 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 (microalbuminuria testing). The 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

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, current medications, conduct a pain assessment, and discussion advanced care planning. The PCP is also 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

Participating PCPs are required to ensure adequate accessibility for health care 24 hours per day, seven days per week. An after-hours telephone number must be available to Members (voicemail 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 24 hours, seven days a week when medically necessary.

**Routine sick member care:** Member must be provided an appointment within seven days of making a request.

**Nonsymptomatic office visits:** Member must be provided an appointment within 30 days of making a request.

**Authorization Timelines:**

- For standard authorization decisions, Humana shall provide the decision notice as expeditiously as the Member's health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for service, or earlier if Humana determines it is in the best interest of the Member.
- For expedited requests, where following the standard time frame could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function, Humana shall make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than 72 hours following receipt of the request for service.

The authorization decisions may be extended for up to (14) calendar days if the Member requests an extension or if there is a need for additional information to make a decision that is in the interest of the Member.

## 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 patients 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 behavioral 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.

## 8.3 Member transfers and panel closures

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

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

When closing a provider panel to new Humana MMP Members, Providers need to:

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

## 8.4 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 meets needs of all Members, including those with physical and non-physical 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.

## 8.5 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 financial issues. Multiple comorbidities, complex conditions, frailty, disability, end-of-life issues, end-stage renal disease, isolation, depression and poly-pharmacy are some of the challenges facing these Members each day.

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

- Integrated care management is delivered within an ICT structure and holistically addresses the needs of each Member.
- 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.
- 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, ensures 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**

- Two 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 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. 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.

## 8.6 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 health care Provider from refusing to furnish any contraceptive or family planning service, supplies or information for medical or religious reasons.

## 8.7 Adult health screening

Adult preventive health exam – Beginning at age 21

| Elements | Guidelines |
|---|---|
| Risk screening | Screening to identify high-risk individuals, assessing family medical and social history is required.<br>Screening for the following risks are included as a minimum: cardiovascular disease, hepatitis, HIV/AIDS, STDS and TB. |
| Interval history | Interval histories are required with preventive health care. Changes in medical, emotional and social status are documented. |
| 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. |
| Height and weight | Documented height and weight is required for all preventive health care visits and at least:<br>• Every five years for ages 21-40<br>• Every two years beginning at age 41 |
| Vital signs | Pulse and blood pressure are required for all preventive health care visits and at least:<br>• Every five years for ages 21-40<br>• Every two years beginning at age 41 |
| Physical exam | Appropriate evaluation for inclusion in the baseline physical examination of an asymptomatic adult are:<br>• General appearance<br>• Skin<br>• Gums/dental/oral<br>• Eyes/ears/nose/throat<br>• Neck/thyroid<br>• Chest/lungs<br>• Lymphatic<br>• Cardiovascular<br>• Breasts<br>• Abdomen/GI<br>• Genital/urinary<br>• Musculoskeletal<br>• Neurological<br>If noncompliance or refusal is documented, the risk associated with the noncompliance must be documented. |
| Cholesterol screening | Screening required every five years for:<br>• Men, beginning at age 35<br>• Women, beginning at age 45<br>(Earlier if there is any risk factor evident for cardiovascular disease) |
| 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. |
| Hearing screening | Test or inquire about hearing periodically/once a year. |
| Electrocardiogram | Periodically after age 40-50 (or as primary care deems medically appropriate). |

| Elements | Guidelines |
|---|---|
| Colorectal cancer screening | Colorectal cancer screening must be documented beginning at age 50.<br>**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. |
| Pap test | Required as appropriate between ages 35 and 40.<br>• Every one to two years for women age 40 or older.<br>• Earlier and/or more frequent for women at high-risk. |
| Mammography | Required as appropriate between ages 35 and 40.<br>• Every one to two years for women age 40 or older.<br>• Earlier and/or more frequent for women at high-risk. |
| Prostate exam/screening | **U.S. Preventive Services Task Force/ December 2002:**<br>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 with 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.<br>**American College of Physicians 2004:**<br>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 difficult to ever justify routine screening of men 70 and older. Health education and guidance must be documented. Guidance needs are based on risk factors identified through personal and family medical history, social and cultural history and current practices. |
| Osteoporosis | Screening for women age 65 and older; begin at age 60 if at increased risk for osteoporotic fractures. Perform DEXA scan for serial monitoring every two years; special conditions may need more frequent monitoring. All perimenopausal women should have a DEXA Scan after a fracture if test has not been performed recently. |

## 8.8 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.

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 (PA), or Nurse Practitioner (NP) 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 week 36, 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 HumanaBeginnings® 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 Social Services of the pregnancy.

(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 28.

(ii) If the Provider determines that the Member's pregnancy is high risk, the Health Plan shall ensure that the Provider'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.

## 8.9 Domestic violence, alcohol and substance use and smoking cessation

PCPs should screen Members for signs of domestic violation, neglect or exploitation and should offer referral services to applicable community agencies. PCPs must report to protective agencies as appropriate any incident that may jeopardize the Member's safety.

**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.

**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.

## 8.10 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** – Medical record review conducted by the Agency or 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 Healthcare Providers and Systems (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 medical record audit or the EQRO indicate that Humana's performance is not acceptable, then the Agency may impose penalties.

## 8.11 Community Outreach Provider Compliance

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

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

(b) Health care Providers cannot orally or in writing compare benefits or Provider networks among Health Plans, other than to confirm whether they participate in a Health Plan's network.

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

(d) Health care Providers may cosponsor events, such as health fairs and advertise with the Health Plan in indirect ways; such as television, radio, posters, fliers and print advertisement.

(e) Health care Providers shall not furnish lists of their Demonstration patients to the Health Plan with which they contract, or any other entity, nor can Providers furnish other Health Plans' membership lists to the Health Plan, nor can Providers assist with Health Plan enrollment. Providers may refer Members to the Virginia Enrollment Broker and Education Services at **1-855-889-5243**, Monday - Friday, 8:30 a.m. - 6 p.m., Eastern time.

(f) For the Health Plan, Providers may distribute information about non-Health-Plan- specific health care services and the provision of health, welfare and social services by the State 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 enrollment broker.

## 8.12 Virginia Medicaid Provider number

All Providers are required to have a unique Virginia Medicaid Provider number in accordance with the guidelines of the Agency. Medical 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. Nonmedical Providers offering Home and Community Based Services (HCBS) must have an Atypical Provider Identifier (API).

**Note:** Providers must register with Virginia Medicaid at: **www.virginiamedicaid.dmas. virginia.gov/wps/portal** to participate in the CCC.

## 8.13 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 Humana be kept informed of your status. This is of real significance if you have an active authorization for a Member. Additional resources can be found at this link: **http://www.vaemergency.gov/ReadyVirginia**.

## 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 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)

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** with your existing user ID and password. If your organization is not yet registered, registration can be completed immediately.

Choose "Resources", in the upper right, locate the "Compliance" section and choose "Required Compliance Events."

If you are not registered at **Humana.com**, the training can be accessed by going to humana.com, selecting "For Providers" in bar at the top then pausing your cursor over the "Medical Providers" section. Select "What's new" from the dropdown box, and the training will be the final selection in the list of "What's new" items.

### Availity.com

Sign in to **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 "Payer Resources" in the upper right, select "Humana" from the list of payers that display in a new window, locate the "Resources" 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.

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 Heath 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 offices.
- In accordance with 42 CFR 438.104(b)(1)(iv), Humana and its subcontractors shall not seek to influence 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 beneficiary must enroll with Humana in order to obtain Medicaid State Plan benefits, or in order not to lose benefits (Medicaid State Plan benefits).
- 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 certified its endorsement in writing to Humana.

## 9. Medical records standards

For each Demonstration 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 health care 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.

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 **1-855-280-4002** 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. Claims submission protocols and standards

## 10.1 Timely filing

Providers are required to timely file their claims/encounters for all services rendered to Demonstration 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 preventive care and screening compliance.

**Note:**

- Medicaid clean claims shall be paid within 14 days of receipt.
- Demonstration Providers are prohibited from billing Members for denied services.
- Demonstration Providers are prohibited from balance billing Members.
- Providers should experience minimal disruption related to the process for allocating, billing and collecting Member pay as the process closely follows normal Medicaid processes.
- Providers should continue to bill the gross amount and may enter the Member pay amount on the claim. Humana will deduct the Member pay amount and remit the net amount.
- With the implementation of the National Provider Identifier (NPI), it will become necessary in some cases to include a taxonomy code on claims submitted to DMAS for all of our programs: Medicaid, FAMIS and SLH. Prior to using the NPI, DMAS assigned a unique number to a provider for each of the service types performed. But with NPI, a provider may only have one NPI and bill for more than one service type with that number. Since claims are adjudicated and paid based on the service type, our system must determine which service type the provider intended to be assigned to a particular claim. If the NPI can represent more than one service type, a taxonomy code must be sent so the appropriate service type can be assigned.

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 365 calendar days.

**Note:** Humana's payer submitter ID is 61101.

## 10.2 Skilled nursing facility billing

- Bill Type – 21x (x = frequency)
- Revenue Code – 120
- Bad debt will be settled on a quarterly basis in 2014 and on claims by 2015.

## 10.3 Home health billing

CMS billing requirements for home health include, but are not limited to, the following:

- Submitting the home health resource group (HHRG) with revenue code 023;
- Submitting the treatment authorization code (TAC), which is obtained through the Medicare OASIS system;
- Submitting the core-based statistical area (CBSA) where services were rendered (submitted with value code 61);
- Using an appropriate home health prospective payment system (PPS) bill type ;
- Billing each visit on a separate claim line;
- Billing each visit with the appropriate CMS-designated revenue and Healthcare Common Procedure Coding System (HCPCS) code combinations;
- Billing units appropriate for the description of the HCPCS code (e.g., CMS visit G-codes represent 15-minute increments of service);
- Billing a claim line for non-routine supplies (NRS) when the HHRG indicates NRS were provided; and
- Billing CMS-required informational Q-codes.

# 11. Cultural competency plan standards

## 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 health care
- Attitudes toward health care Providers

**Culture impacts every health care 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 health care 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. More than 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 Humana member ID card to access interpretation services while the Member is in the office
- Spanish versions of Humana's non-secure 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 Care phone number listed on the back of the Humana member ID card to request translated materials.

## Cultural Competence – subcultures and populations

With growing concerns about health inequities and the need for health care 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 American society, which can differ among ethnic groups. Each population has its health issues, such as the white American, Asian, African American and Latino American, as well as gender.

"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 is also an important aspect of cross-culture health care.

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 behavioral health
- Visual impairment
- Hearing impairment
- Physical impairment

Additional information on this topic is included in Humana's required Cultural Competency annual compliance training as identified by Humana. Please refer to subsection 8.13 of Section I of this Appendix for more information on how to access this required annual training.

# 12. Member rights and responsibilities standards

### 12.1 Member rights

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

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 isn't being protected.
9. A Member has the right to be given by the health care Provider information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
10. A Member has the right to participate in decisions regarding his or her health care, including the right to refuse treatment, except as otherwise provided by law.
11. 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.
12. A Member who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care Provider or health care facility accepts the Medicare assignment rate.
13. A Member has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

14. 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.
15. 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.
16. A Member has the right to be furnished health care services in accordance with federal and State regulations.
17. A Member has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap or source of payment.
18. A Member has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
19. 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.
20. 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.
21. 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.
22. A Member has the right to express Grievances regarding any violation of his or her rights, as stated by Virginia law, through the Grievance procedure of the health care Provider or health care facility which served him or her and to the appropriate State licensing agency.

## 12.2 Member responsibilities

1. A Member is responsible for providing to the health care Provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his or her health.
2. A Member is responsible for reporting unexpected changes in his or her condition to the health care Provider.
3. A Member is responsible for 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 health care 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 health care 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 health care Provider or health care facility.
7. A Member is responsible for his or her actions if he or she refuses treatment or does not follow the health care Provider's instructions.
8. A Member is responsible for following health care facility rules and regulations affecting patient care and conduct.
9. A Member is responsible for paying the Patient Pay amount that is determined by the Department of Social Services (DSS) to the LTSS Provider who provides the largest portion of the Member's care, e.g., Nursing Facility, Personal Care, Adult Day Health Care.

# 13. Fraud, waste and abuse policy standards

Both the federal government and the individual states that are establishing and monitoring requirements for Medicaid are trying to reduce fraud, waste and abuse (FWA) in the Medicaid program. Healthcare FWA can involve physicians, pharmacists, Members and medical equipment companies. Success in combating health care 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 violations of ethical standards.

Additional information on this topic is included in Humana's required Fraud, Waste and Abuse Detection, Correction and Prevention annual compliance training as identified by Humana. Please refer to subsection 8.13 of Section I for more detailed information and directions regarding how to access this 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 LDSS and the Humana Care Manager who is participating on the Member's ICT. This includes, but is not limited to:

- **Abuse** – Non-accidental infliction of physical and/or emotional harm.
- **Physical abuse** – Causing the infliction of physical pain or injury.
- **Sexual abuse** – Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity; touching, fondling, sexual threats, sexually inappropriate remarks or any other sexual activity; when the person is unable to understand, unwilling to consent, threatened or physically forced to engage in sexual activity.

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- **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 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 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. 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 who 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 subsection 8.13 of Section I for more detailed information and directions regarding how to access this required annual training.

# SECTION II — LONG-TERM SERVICES AND SUPPORTS (LTSS)

## 1. Introduction

Humana issues this Provider Manual Appendix to you after your credentialing is complete, if not before. 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 Appendix from a website. This notification would also detail how you can request a hard copy at no charge.

### 1.1 Welcome

As an LTSS professional, you play a very important role in the delivery of health care services to the Demonstration Members. This section of the Appendix will provide additional information for the provision of covered services to Demonstration Members. This Appendix contains policies, procedures and general reference information including minimum standards of care which are required of Health Plan Providers.

### 1.2 Changes in policy

This document is referenced in and supports your Provider Agreement. While every effort is made to keep the content of this document current, Humana reserves the right to modify, suspend or terminate any of the policies, procedures and/or benefits described in the Appendix with or without prior notice to Providers. The Health Plan shall disseminate bulletins as needed to incorporate any needed changes to the Appendix.

### 1.3 Agency–directed (AD) and consumer-directed (CD) models of care

LTSS Members may receive EDCD Waiver Services, e.g., Personal Care, ADHC, Respite (skilled and non-skilled), Service Facilitation and Personal Emergency Response System (PERS) through an agency-directed model of care. LTSS Members may also receive Personal Care and Non-skilled Respite through a consumer-directed model of care.

Humana will only reimburse for services provided when the Member is present, according to an approved Plan of Care, when the services are authorized, and when a qualified Provider is providing the services to the individual. Humana will not pay for services rendered to or for the convenience of other members of the household. A Member may receive CD services along with AD services. However, Members cannot simultaneously (same billable hours) receive multiple/duplicative services. Simultaneous billing of personal care and respite care services is not permitted. Personal care, with the exception of Instrumental Activities of Daily Living (IADL) hours which must be shared when two LTSS Members reside in the same household, may only be provided to one Member at a time.

For both AD and CD care, the Member must have a viable back-up plan (e.g. a family member, neighbor or friend willing and available to assist the Member, etc.) in case the personal care aide/attendant is unable to work as expected or terminates employment without prior notice. This is the responsibility of the Member and family and must be identified in the assessment or Plan of Care. Members who do not have viable backup plans are not eligible for services until viable backup plans have been developed.

For AD care, the Provider must make a reasonable attempt to send a substitute aide but, if this is not possible, the Member must have someone available to perform the services needed.

### 1.4 EDCD waiver referrals

Initial Level of Care (LOC) determinations for individuals enrolled in or seeking Enrollment in the EDCD Waiver or Nursing Facility (NF) admission will be conducted by Pre-Admission Screening (PAS) Team entities using the Uniform Assessment Instrument (UAI). For Enrollees who have been enrolled in the EDCD Waiver or admitted to a NF prior to enrolling in the Demonstration, the Provider will be requested to send information collected from the UAI to Humana if it is available. Humana's Care Management team will use information obtained from the UAI and other assessments in the development of the Enrollee's POC which will be available for providers to view by logging into the secured Humana.com provider portal site or through request by contacting the Care Management team at **1-800-559-3581**, Monday - Friday between 8 a.m. and 5 p.m., Eastern time.

Providers identifying enrollees who do not currently receive EDCD services but may be eligible should contact the Humana Care Management team at **1-800-559-3581**, Monday – Friday, between 8:30 a.m. – 5 p.m., Eastern time, to initiate referral to the appropriate PAS Team for conducting pre-admission screening. Humana will use information obtained from the UAI in the development of the Enrollee's POC. Reassessments of each enrollee's Level of Care and continued eligibility for EDCD Waiver services will be conducted at least annually or more frequently as the enrollee's health status changes.

## 2. Provider status and credentialing

The LTSS Provider has the responsibility of providing the necessary items for contracting. All applicable Providers must be credentialed prior to their contract effective date with the Health Plan and re-credentialed every three years. General medical Provider credentialing requirements for all Providers are set forth in Humana's Provider Manual for Physicians,

Hospitals and Healthcare Providers. For HCBS and/or atypical Providers, please see subsection 6 of Section II of this Appendix for an outline of HCBS and atypical Provider verification requirements.

## 3. Provider Policies and Responsibilities section

### 3.1 Equal Provider opportunity and Provider hiring

Humana is an equal Provider opportunity organization. Provider decisions 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 affiliation or any other factor protected by law.

Provider shall employ only individuals who may legally work in the United States, either U.S. citizens or foreign citizens who are authorized to work in the U.S., in compliance with the Immigration Reform and Control Act of 1986 which prohibits employers from knowingly hiring illegal workers.

Provider should utilize the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system, or similar system, to verify the employment eligibility of all persons employed by the Provider to perform employment duties within the State and all persons (including subcontractors) assigned by the Provider to perform work pursuant to the Provider Agreement. The Provider should include this paragraph in all subcontracts it enters into for the performance of work under the Provider Agreement.

## 3.2 Contract, law and license compliance

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

## 3.3 Provider background check

Background screening rules may change. Please refer to the DMAS website for the most current information regarding Provider licensing.

Note: A background check may be necessary depending on the service and Provider type. A comprehensive background check may include prior Provider verification, professional reference checks, education confirmation and the OIG (Office of Inspector General).

### 3.3.1 Criminal record check and criminal allegations

Most Provider licenses require a criminal record check be performed prior to issue of license. Humana will not duplicate such efforts if possible, but reserves the right to request a criminal record check to protect the interest of our 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 Agency. Humana must investigate allegations regarding falsification of client information, service records, payment requests and other related information. If Humana has reason to believe falsification or the like has occurred, the allegations will be referred to the State Attorney, a law enforcement agency, the United States Attorney's Office, or other governmental agency. Humana is required to notify the Inspector General at the Agency immediately. A copy of all documents, reports, notes or other written materials concerning the investigation, whether in the possession of the Health Plan or subcontractor, must be sent to the Agency's Inspector General with a summary of the investigation and allegations.

## 3.4 HIPAA standards

The task of handling Member records and related administration functions is accomplished with consideration to HIPAA. Member files will be kept confidential at all times and include the following precautions:

- Only request and work with Protected Health Information (PHI) related to "treatment, payment or health care operations."
- Implementation of a privacy and security policy and with annual training.
- Email should not be used to transfer files with Member information unless it is encrypted.
- Fax machines should be positioned for privacy.
- Fax numbers should be confirmed before sending information to Health Plan.
- Leave minimum data on voicemail.
- Block public observation of workstation screens, display screens and/or display monitors whenever possible by closing software applications, turning monitors off or away from open viewing areas and walkways, or using filter screens that limit monitor viewing.

## 3.5 Change in Provider data

Changes in practice name, legal entity or tax ID numbers may require an amendment, assignment or new Agreement depending on the reason for the change. Check with the Provider representative in the local Humana office for specific information. Please contact Humana Provider Relations at **1-855-280-4002**.

## 3.6 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 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 11 above.

For information on Humana's Health, Safety, and Welfare Training, see Section I – General Provider Information, subsection 14 above.

For information on Humana's Fraud, Waste and Abuse Training, see Section I – General Provider Information, subsection 13 above.

Additional information on these topics is included in Humana's required annual compliance training as identified by Humana. Please contact Humana Provider Relations at 1-855-280-4002 for help in understanding how to access this required training.

# 4. Standards of conduct

## 4.1 Reporting attendance and significant health events

- Providers will provide notice to the Health Plan Care Manager or Care Coordinator within 24 hours when a Member dies, leaves the facility, or moves to a new residence.
- LTC Provider will also report Member Adverse Events to the Health Plan Care Manager and will assist Health Plan with review. Such adverse events would include the following:
- Adverse events required by rule or law to be reported to regulatory authorities such as neglect, abuse, exploitation and fraud.
  - Decline in management of medications
  - Falls or accidents (with or without injury)
  - Significant worsening of ADLs
  - Two or more behavioral problems
  - Significant change in toileting ability
  - Disaster that leaves Provider facility diminished
- All Adverse Event reporting and Reviews are part of the Quality Initiatives for both Health Plan and Provider. This Quality Initiative and Risk Management process anticipates the information will not be included in the discoverable elements of the Member file.

The Provider has the responsibility of providing the necessary items for claims processing. The claims procedure should be reasonable and the Health Plan response to the claim timely. For Medicaid services only, nursing facility, Adult Day Health Care (ADHC) facility, personal emergency response systems, personal and respite care, assisted technology and pest control, Providers should adhere to the Humana policies and procedures set forth below.

# 5. Claims submission protocols and standards

## 5.1 Provider billing for services

Note: "Patient pay" is the amount of the LTSS patient's income which must be paid as the patient's share of the Medicaid LTC services cost. The Provider is responsible for collection of the Patient Pay from the member each month. The amount collected is determined by the Commonwealth of Virginia's Department of Social Services (DSS). The Patient Pay amount is deducted by the Provider on the appropriate claim form.

The claim form is then submitted for payment to the Health Plan. The Health Plan reimburses at the contractual negotiated rate minus the Patient Pay amount.

As a network Provider you would receive payment and provide services and supplies according to your Agreement with Humana and all information required for a clean or complete claim. Nursing Facilities shall submit Medicare claims utilizing the UB-04 billing form while all other LTSS providers shall utilize the CMS-1500 (formerly known as the HCFA 1500) to Humana. Claims may be submitted on paper or sent electronically. The Humana Payer ID to be used is 61115. Humana has partnered with Availity to receive claims via a Direct Data Entry process or electronic claim submission.

The following link provides additional information regarding Availity:

**www.humana.com/provider/medical-providers/education/claims/electronic-submission**

Health care providers also may file claims electronically through the clearinghouse of their choice. Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for information.

When submitting claims to a clearinghouse, you may use the following payer IDs for Humana or send paper claims to:
Humana LTSS Claims (payer ID 61115)
P.O. Box 14732
Lexington, KY 40512-4732
**Note:** Please send skilled claims to Humana (payer ID 61101):
Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

All claims that involve other insurance must be accompanied by an Explanation of Benefits (EOB) or a remittance advice that clearly states how the claim was paid or the reason for denial.

## 5.2 Clean claim submissions

Humana 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 defined 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 services as described in Mandates, including, but not limited to:

The Provider must mail or electronically transfer (submit) the claim to the Health Plan within six (6) months after: 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 (the timeline is 12 months for core Medicare).

### Claims payment time frames

Humana processes clean claims according to the following time frames:

- Medicaid clean claims will be processed within 14 days of receipt.

**Note:** It is preferred that nursing facilities bill skilled and custodial services separately as follows on a UB-04:

**Skilled/specialized –**

- For facilities certified to offer skilled services, bill with a revenue code 12X and type of bill 021X

**Intermediate/custodial services –**

- For facilities certified to offer skilled services, bill with revenue code 190 and type of bill 021X
- For facilities without this certification, please use TOB 062X with revenue code 190

### Claims resubmission

A claim for resubmission will only be considered if it is re-billed in its entirety within 180 days from date of service. Provider must include a letter outlining the reason for submission.

### Overpayment/Underpayment

Humana provides 30 days written notice to health care Providers before engaging in overpayment recovery efforts, allowing the health care 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 60 days following its initial identification. In addition, the Provider must provide Humana with a written reason for the overpayment (e.g., excess payment under coordination of benefits, etc.).

### Claims inquiries

Providers can check the status of claims by contacting the Humana Claims Department at **1-855-280-4002**.

## 5.3 Prior authorization and referral procedures

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.

All services listed for the CCC program require a review and approval by the care coordinator. These services include:

- Personal care
- Respite care
- Adult Day Health Care (ADHC)
- Personal Emergency Response System (PERS)
- Transition services
- Service facilitation

**Note:** SNF Notification/Authorizations are unique and should adhere to the below:

Notifications are submitted online at **Humana.com**. Clinical information can be attached immediately online or faxed to **1-888-618-2646**.

- The cover sheet should include the Member's name, date of birth and Humana Member identification number.
- Notifications that follow the prior authorization process are approved for seven days based on medical necessity.
- Once the notification is completed, a utilization management case manager contacts the facility for continued stay authorizations.
- Utilization management case managers are available Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

**Note:** For Part B therapy, please contact Orthonet for authorizations at **1-800-862-4006**. For provider online access to OrthoNet forms: **www.orthonet-online.com/dl_humana.html**

The Plan will ensure that applicable criteria is utilized when making authorization decisions with consideration given to characteristics of the local delivery systems available for specific Members as well as Member-specific factors, such as Member's age, co-morbidities, complications, progress in treatment, psychosocial situation, home environment and to promote the concept of appropriate care for the appropriate condition in the most cost-effective setting. Prior authorization review determinations will be based solely on the information obtained at the time of the review. If needed, a Medical Director will review any services request before a denial of service authorization occurs. The care coordinator will send you the Authorization Forms, if applicable. For providers to access forms for authorizations for Orthonet, **www.orthonet-online.com/dl_humana.html**.

### 5.4 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 Health Plan manages this process through an approved policy and procedure and is available upon request

## 6. Grievance and Appeals

Humana's Grievance and Appeals processes are set forth in detail in Humana's Provider Manual for Physicians, Hospitals and Healthcare Providers, Section V. Providers can call the Virginia State Corporation Commission, Bureau of Insurance to report Complaints. Internal appeals must be exhausted pursuant to the terms of the CCC.

Phone: **1-800-552-7945**

Website: **www.cms.gov/cciio/Resources/consumer-assistance-grants/va.html**

## 7. 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.

# SECTION III – BEHAVIORAL HEALTH

## 1. Program description

### 1.1 Beacon/Humana partnership

Humana has partnered with Beacon Health Strategies, LLC to manage the delivery of behavioral health services for its dually eligible Members in the State. Beacon Health Strategies, LLC is a limited liability, managed behavioral health care company. Established in 1996, Beacon's mission is to collaborate with our health plan customers and network Providers to improve the delivery of behavioral health care for the Members we serve.

Beacon provides behavioral health management services to 9.2 million people, through partnerships with more than 50 health plan partners in 21 states. Most often co-located at the physical location of our 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 "behavioral health home" model. Quantifiable results prove that this approach improves the lives of individuals and their families and helps plans to better integrate behavioral health with medical health.

Humana has delegated behavioral health-related functions to Beacon. These include:

1) Contracting and credentialing of behavioral health Providers;
2) Utilization review and medical management for behavioral health services;
3) Administrative appeals (Humana will process clinical appeals);
4) Claims processing and payment;
5) Member rights and responsibilities;
6) Quality management and improvement;
7) Member services, including management of the Behavioral Health Hotline;
8) Referral and triage;
9) Ensuring service accessibility and availability;
10) Treatment record compliance; and
11) Care management.

### 1.2 Beacon/Humana behavioral health program

The Beacon/Humana behavioral health program provides Members with access to a full continuum of behavioral health services through our network of 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 Plan Members receive timely access to clinically appropriate behavioral health care services, Humana and Beacon believe that quality clinical services can achieve improved outcomes for our Members.

Humana and Beacon will collaborate with the Community Service Boards (CSB) when there are existing relationships with dual-eligible members receiving care from their Centers. This collaboration will include assessment, care planning, service delivery and participation on the ICT.

When a dual–eligible member is identified by Humana Cares as receiving BH services from a CSB, and meeting primary BH criteria, the Beacon Care Manager will reach out to the CSB Care Manager at the time of enrollment and begin to collaborate for the Member's care needs.

## 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 **Miami_Partners@beaconhealthoptions.com**, or by phone between 8 a.m. – 8 p.m., Eastern time, Monday – Friday, at **1-855-765- 9704** for routine matters. Additionally, Beacon's clinical staff is available 24 hours a day, seven days a week for authorization requests by calling **1-855-765-9704**.

## 1.4 Contracting and maintaining network participation

A "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/or Humana. Network Providers agree to provide covered behavioral health and/or substance use 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.

Network Providers who maintain approved credentialing status remain active network participants unless the PSA is terminated in accordance with the terms and conditions set forth therein. In cases where a Provider is terminated, 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 section of the Manual Appendix is a legal document incorporated by reference as part of each Provider's Beacon/Humana Provider Services Agreement.

Beacon's level-of-care criteria (LOCC) are accessible through eServices or by calling Beacon at **1-855-765-9704**. More can be found on the Beacon Provider portal: provider.beaconhs.com.

The Appendix is posted on both Humana's 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 Appendix by calling **1-855-765-9704**.

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

**Electronic media**

To streamline 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 Providers contracted for Humana and is accessible through www.beaconhs.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. Claims status is available within two hours of electronic submission. All transactions generate printable confirmations, and transaction histories are 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.

Providers may register online 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 the 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.partnerships@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 **1-855-765-9704** Opt. 1.

In order to maintain compliance with HIPAA and all other federal and State confidentiality/privacy requirements, Providers must have their practice or organizational tax identification number (TIN), national provider identifier (NPI), as well as the 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 health care 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.html**, then contact **edi.operations@beaconhealthoptions.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.

**TABLE 1-1: ELECTRONIC TRANSACTIONS AVAILABILITY**

| Transaction/Capability | eServices at beaconhs.com | IVR 1-888-210-2018 | EDI at beaconhs.com |
|---|---|---|---|
| Verify Member eligibility, benefits | 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) |

| Transaction/Capability | eServices at beaconhs.com | IVR 1-888-210-2018 | EDI at beaconhs.com |
|---|---|---|---|
| View claims status | Yes | Yes | NA |
| Print claims reports and graphs | Yes | | |
| Download electronic remittance advice | Yes | | NA |
| 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 Appendix | Yes | | |

**Email**

Beacon encourages Providers to communicate with Beacon by email at Miami_partners@beaconhealthoptions.com. Throughout the year Beacon sends 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.

## 1.7 Access standards

Humana Members may access behavioral health services 24 hours a day, seven days a week by contacting **1-855-765-9704**. The line includes an option for connecting directly to Beacon Health Strategies 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 |
|---|---|
| Non-life-threatening emergency | Within six (6) hours |
| Urgent care | Within forty-eight (48) hours |
| Post discharge from acute hospitalization | Within seven (7) calendar days of discharge |
| Other routine referrals/appointments | Within ten (10) business days |

Access standards for Humana's behavioral health network are established to ensure that Members have adequate access to Providers.

### Travel time standard

Each Member shall have access to two Providers of each service type located within no more than thirty (30) minutes travel time in an urban area.

Each Member shall have access to two Providers of each service type located within no more than sixty (60) minutes travel time in a rural area. Travel time shall be determined based on driving normal traffic conditions, not during commuting hours.

### Travel distance standard

Each Member shall have access to two Providers of each service type located within no more than fifteen (15) miles travel distance in an urban area, and thirty (30) miles travel distance in a rural area.

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

| Service availability | Hours of operation: |
|---|---|
| On-call | • 24 hour on-call services for all Members in treatment; and<br>• 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;<br>• Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours; and<br>• 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 through Friday from 9 a.m. – 5 p.m. at a minimum; and<br>• Evening and/or weekend hours should also 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. |

### Behavioral Health Homes

All Providers are encouraged to consider an affiliation with a Behavioral Health Home. Some Providers may serve as a Behavioral Health Home, which is designed to provide fully integrated care for Members. For further information on the Behavioral Health Home model, please contact us at **1-855-765-9704**.

### 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 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 to meet all regulatory 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.partnerships@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. Further, Providers may not charge the Plan 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 of this membership and to follow the procedures set forth in this Appendix.

### 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 is either 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 **1-855-765-9704**. 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 **1-855-765-9704**.

### 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 1-855-765-9704. 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 and accessibility 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 1-4: REQUIRED NOTIFICATION |
|---|
| 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 hours of operation; |
| Is no longer accepting new patients; |
| 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; or |
| Merger, change in ownership, or change of tax identification number |
| When adding a site, service or program not previously included in the Behavioral Health Services Agreement, remember to specify:<br>a) Location; and<br>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 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. Member, benefits and Member-related policies

## 2.1 Covered services

Humana covers behavioral health and substance use services via Beacon to Members in five regions, which include Central Virginia, Northern Virginia, Tidewater, Western/Charlottesville and Roanoke. For a list of all counties served by the plan, please refer to Appendix B. Under the Plan, the following levels of care are covered, provided that 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 Appendix 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
- Substance use services
- Behavioral health rehabilitation services
- Partial hospitalization
- Intensive outpatient services (behavioral health)
- Inpatient hospitalization
- Crisis stabilization and observation
- Emergency services
- Day treatment
- Care management 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 PCP. Some behavioral health and substance use services for CCC.

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 primary care and other treating Providers whenever possible.

**Additional benefit information:**

Benefits do not include payment for behavioral health care 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 non-health care services such as the costs of managing research or the costs of collecting data that is useful for the research project, but not necessary for the Member's care.
- Authorization may be required for all services except emergency services. Detailed information about authorization procedures is covered in subsection 4 of the Behavioral Health Section of Appendix.

## 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 health care Providers, and that collaboration among Providers is also crucial to achieving positive health care 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 above in the General Provider Information, Section I

### 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 **1-855-765-9704** or by **TTY** at **1-855-371-3939**.

### 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.

### Non-discrimination 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 behavioral 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.

Providers may not close their practice to 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 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 health care operations at the sign-up for health insurance. Treatment, payment and health care 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 is 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 Provider should clearly document the Member's reason for refusal in the narrative section on the form.

### Confidentiality of Members' HIV-related information

At every intake and admission to treatment, Providers should explain the purpose and benefits of how 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 Plans' medical and disease management programs and accepts referrals for behavioral health care management from health plans. 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 the Health Plan. Beacon will assist behavioral health Providers or Members interested in obtaining any of this information by referring them to the 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 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:

**Member Eligibility**

Sign in to Beacon eServices or call Beacon's IVR: **1-888-210-2018**

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 **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 **1-855-765-9704** 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 other federal and State confidentiality/ privacy requirements, Providers must have their practice or organizational TIN, NPI (or API), as well as Member's full name, Plan ID and date of birth, when verifying eligibility through eServices and through Beacon's IVR.

# 3. Quality Management and Improvement

The Beacon Clinical Department may also assist the Provider in verifying the Member's enrollment in the Humana plan when authorizing services. Due to the implementation of the privacy act, Beacon requires the Provider to have ready specific identifying information (Provider ID number, Member 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.

## 3.1 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 the goal of which is to continually monitor and improve the quality and effectiveness of behavioral health services deli ered 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;<br>• Identify areas for targeted improvements;<br>• Develop QI action plans to address improvement needs; and<br>• Continually monitor the effectiveness of changes implemented, over time. | Improve the health care status of Members;<br>• Enhance continuity and coordination among behavioral health care Providers and between behavioral health care and physical health care Providers;<br>• Establish effective and cost–efficient disease management programs, including preventive and screening programs to decrease incidence and prevalence of behavioral health disorders;<br>• Ensure Members receive timely and satisfactory service from Beacon and network Providers;<br>• Maintain positive and collaborative working relationships with network practitioners and ensure Provider satisfaction with Beacon services; and<br>• Responsibly contain health care 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 **Miami_Partners@beaconhealthoptions.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;
- Timeliness of ambulatory follow-up after behavioral health hospitalization;
- Discharge Planning Activities;
- Communication with Member PCPs, other behavioral health Providers, government and community agencies;
- Tracking of adverse incidents, complaints, grievances and appeals; and
- 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 the 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 the Treatment Record Standards and specific quality initiatives established each year. The following elements are evaluated in addition to any Virginia-specific regulatory requirements:

- Use of screening tools for diagnostic assessment of substance use 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 onsite 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 Members' information should be directed to Beacon's Compliance Office at **Compliance@beaconhealthoptions.com** HIPAA regulations permit Providers to disclose information without patient authorization for the following reasons: "oversight of the health care system, including quality assurance activities." Beacon chart reviews fall within this area of allowable disclosure.

### Treatment records 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 where indicated.

**TABLE 3-2: TREATMENT DOCUMENTATION STANDARDS**

| | |
|---|---|
| Member identification information | The treatment record contains the following Member information:<br>• Member name and health plan ID number on every page;<br>• Member's address;<br>• Employer or school;<br>• Home, work and cellular (if applicable) telephone number ;<br>• Marital/legal status;<br>• Appropriate consent forms; and<br>• Guardianship information, if applicable. |
| Informed Member consent for treatment | The treatment record contains signed consents for the following:<br>• Implementation of the proposed treatment plan;<br>• Any prescribed medications;<br>• Consent forms related to interagency communications;<br>• 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;<br>• 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.);<br>• For adolescents ages 12–17, the treatment record contains consent to discuss behavioral health issues with their parents; and<br>• Signed document indicating review of Member's Rights and Responsibilities. |
| Medication information | Treatment records contain medication logs clearly documenting the following:<br>• All medications prescribed;<br>• Dosage of each medication;<br>• Dates of initial prescriptions;<br>• Information regarding allergies and adverse reactions; and<br>• Lack of known allergies and sensitivities to substances. |

| TABLE 3-2: TREATMENT DOCUMENTATION STANDARDS | |
|---|---|
| Medical and psychiatric history | Treatment record contains the Member's medical and psychiatric history including:<br>• Previous dates of treatment;<br>• Names of Providers;<br>• Therapeutic interventions;<br>• Effectiveness of previous interventions;<br>• Sources of clinical information;<br>• Relevant family information;<br>• Results of relevant laboratory tests;<br>• Previous consultation and evaluation reports; and<br>• Documentation of Advance Directives |
| Substance use information | Documentation of past and present use of the following:<br>• Cigarettes;<br>• Alcohol; and illicit, prescribed, and over-the-counter drugs. |
| 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;<br>• All relevant medical conditions are clearly documented, and updated as appropriate;<br>• Member's presenting problems and the psychological and social conditions that affect their medical and psychiatric status;<br>A complete behavioral status evaluation is included in the treatment record, which documents the Member's:<br>a. Affect;<br>b. Speech;<br>c. Mood;<br>d. Thought control, including memory;<br>e. Judgment;<br>f. Insight;<br>g. Attention/concentration;<br>h. Impulse control;<br>i. Initial diagnostic evaluation and DSM IV diagnosis that is consistent with the stated presenting problems, history, behavioral status evaluation<br>j. Diagnoses updated at least quarterly. |
| Treatment planning | The treatment record contains clear documentation of the following:<br>• Initial and updated treatment plans consistent with the Member's diagnoses, goals and progress;<br>• Objective and measurable goals with clearly defined time frames for achieving goals or resolving the identified problems;<br>• Treatment interventions utilized and their consistency with stated treatment goals and objectives;<br>• Member, family and/or guardian's involvement in treatment planning, treatment plan meetings and discharge planning; and<br>• Copy of Outpatient Review Form(s) submitted, if applicable. |

| TABLE 3-2: TREATMENT DOCUMENTATION STANDARDS | |
|---|---|
| Treatment documentation | The treatment record contains clear documentation of the following:<br>• Ongoing progress notes that document the Member's progress towards goals, as well as their strengths and limitations in achieving said goals and objectives;<br>• Referrals to diversionary levels of care and services if the Member requires increased interventions resulting from homicidal or suicidal ideation/intent or the inability to function on a day-to-day basis;<br>• 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<br>• Member's response to medications and somatic therapies. |
| Coordination and continuity of care | The treatment record contains clear documentation of the following:<br>• Documentation of communication and coordination between behavioral health Providers, primary care physicians, ancillary Providers, and health care facilities; and<br>• 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:<br>• Telephone intake/request for treatment;<br>• Face sheet;<br>• Termination and/or transfer summary, if applicable; and<br>• The following clinician information on every entry (e.g., progress notes, treatment notes, treatment plan and updates) should include the following treating clinician information:<br>a. Clinician's name<br>b. Professional degree<br>c. Licensure<br>d. NPI or Beacon identification number, if applicable<br>e. Clinician signatures with dates |
| Additional information for inpatient and diversionary levels of care | These elements are required for inpatient medical records:<br>• Referral information (ESP evaluation);<br>• Admission history and physical condition;<br>• Admission evaluations;<br>• Medication records;<br>• Consultations;<br>• Laboratory and X-ray reports; and<br>• Discharge summary and Discharge Review Form. |

### 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 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.

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

Forms and documentation regarding advanced directives can be downloaded from **www.vsb.org/site/public/healthcare-decisions-day**.

### 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 above.)

### 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 and substance use disorders 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's primary care Providers, with Member's consent. Providers are expected to submit quarterly (monthly if applicable) reports to PCP on Member treatment and progress.

Beacon receives aggregate data from Providers 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:<br>• Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first;<br>• Updates at least quarterly during the course of treatment;<br>• Notice of initiation and any subsequent modification of psychotropic medications; and<br>• Notice of treatment termination within two weeks<br>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/providers.html, or their own form that includes the following information:<br>• Presenting problem/reason for admission;<br>• Date of admission;<br>• Admitting diagnosis;<br>• Preliminary treatment plan;<br>• Currently prescribed medications;<br>• Proposed discharge plan; and<br>• Behavioral health Provider contact name and telephone number.<br>Request for PCP response by fax or mail within three business days of the request to include the following health information:<br>• Status of immunizations;<br>• Date of last visit;<br>• Dates and reasons for any and all hospitalizations;<br>• Ongoing medical illness;<br>• Current medications;<br>• Adverse medication reactions, including sensitivity<br>• allergies;<br>• History of psychopharmacological trials; and<br>• Any other medically relevant information.<br>Outpatient Providers' compliance with communication standards is monitored through requests for authorization submitted by the Provider and through chart reviews. | 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 must also 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:<br>• Date of discharge;<br>• Diagnosis;<br>• Medications;<br>• Discharge plan; and<br>• Aftercare services for each type, including:<br>- Name of Provider;<br>- Date of first appointment;<br>- Recommended frequency of appointments; and<br>- Treatment plan.<br>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.<br>Acute care Providers' communication requirements are addressed during continued stay and discharge reviews and documented in Beacon's Member record. |

### 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.

The information below contains details about the continuity of care requirements under the demonstration. Members are eligible for transitional care for 180 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. Routine outpatient behavioral health treatment by an out-of-network Provider is not an authorized service covered by Beacon outside of the continuity of care guidelines listed below. (The continuity of care information is also noted above.)

### Continuity of Care

Please see Section I, subsection 4 of the General Provider Information above.

### Follow up after behavioral health hospitalization

All inpatient Providers are required to coordinate aftercare 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 outreaching 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 support they need to maintain placement in the community and to prevent unnecessary readmissions.

## 3.3 Reportable incidents and events

Beacon requires that all Providers report adverse incidents, other reportable incidents and sentinel events involving Humana Members to Beacon as follows by calling **1-855-765-9704**.

**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 warants serious concern. |

## TABLE 3-4: REPORTABLE INCIDENTS

| | Adverse incidents | Sentinel events | Other reportable incidents |
|---|---|---|---|
| Incident/event description: | • All medicolegal or non-medicolegal deaths;<br>• Any absence without authorization (AWA) involving a Member who does not meet the criteria above;<br>• 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;<br>• Any sexual assault or alleged sexual assault;<br>• Any physical assault or alleged physical assault by a staff person or another patient against a Member;<br>• Any medication error or suicide at tempt that requires medical attention beyond general first aid procedures;<br>• Any unscheduled event that results in the temporary evacuation of a program or facility (e.g., fire resulting in response by fire department); | • All medicolegal deaths;<br>• Any medicolegal death is any death required to be reported to the Medical Examiner or in which the Medical Examiner takes jurisdiction;<br>• Any (AWA) involving a patient involuntarily admitted or committed and/or who is at high risk of harm to self or others;<br>• Any serious injury resulting in hospitalization for medical treatment;<br>• 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;<br>• Any medication error or suicide at tempt that requires medical attention beyond general first aid procedures;<br>• Any sexual assault or alleged sexual assault;<br>• Any physical assault or alleged physical assault by a staff person against a Member; and<br>• 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 a Member. | • Any non-medicolegal death;<br>• Any AWA from a facility involving a Member who does not meet the criteria for a sentinel event as described above;<br>• Any physical assault or alleged physical assault by or against a Member that does not meet the criteria of a sentinel event;<br>• Any serious injury while in a 24–hour program requiring medical treatment, but not hospitalization;<br>• 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; and<br>• 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. |

| TABLE 3-4: REPORTABLE INCIDENTS | |
|---|---|
| Reporting method: | • Beacon's Clinical Department is available 24 hours a day;<br>• Providers must call, regardless of the hour, to report such incidents;<br>• Providers should direct all such reports to their Beacon clinical manager or UR clinician by phone;<br>• 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**; and<br>• 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:<br>• All relevant information related to the nature of the incident;<br>• The parties involved (names and telephone numbers); and<br>• The Member's current condition. |

# 4. Care management

## 4.1 Care coordination

Beacon will work closely with Community Services Boards (CSB) and other private Providers who may be providing Targeted Case Management (TCM) to Members who are enrolled in the Humana CCC program. Though carved out of the Demonstration, Members may continue to receive TCM services through Medicaid fee-for-service in addition to any covered service through CCC. Community Based TCM's are valuable members of the Integrated Care Team. Beacon will provide a liaison to each CSB to ensure that CSB staff is fully integrated in to the Member's care team, and to provide technical assistance related to the requirements under the Demonstration. For additional information on Model of Care and Care Coordination, please see Section I of this Appendix related to General Provider Information.

## 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, health care 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 UM decisions are based upon Beacon's Level of Care/Medical Necessity Criteria (LOCC);
- Financial incentives based on an individual UM clinician's number of adverse determinations or denials of payment are prohibited; and
- 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.

## 4.3 Level of care criteria (LOCC)

Beacon's LOCC are the basis for all medical necessity determinations and accessible through eServices, includes Beacon's specific LOCC for Virginia 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 Abuse and Mental 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 with which the practitioner does not agree with) an admission, continued inpatient stay, or the availability of any other behavioral health care service, for:<br>• Failure to meet the requirements for coverage based on medical necessity,<br>• Appropriateness of health care setting and level-of-care effectiveness, or<br>• Health Plan benefits. |
| Adverse Action | The following actions or inactions by Beacon or the Provider organization:<br>1. 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;<br>2. Beacon's denial or limited authorization of a requested service, including the determination that a requested service is not a covered service;<br>3. Beacon's reduction, suspension or termination of a previous authorization for a service;<br>4. 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:<br>a. Failure to follow prior authorization procedures<br>b. Failure to follow referral rules<br>c. Failure to file a timely claim<br>5. Beacon's failure to act within the time frames for making authorization decisions;<br>6. Beacon's failure to act within the time frames for making appeal decisions. |

| TABLE 4-1: UM TERMS AND DEFINITIONS | |
|---|---|
| Non-urgent 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 non-urgent 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 non-acute treatment setting. |
| Non-urgent Pre-service Review & Decision | Any case or service that must be approved before the Member obtains care or services. A non-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 non-acute treatment setting. |
| Post-service Review & Decision (Retrospective Decision) | Any review for care or services that have already been received. A post-service decision would authorize, modify or deny payment for a completed course of treatment where a pre-service 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 non-urgent care decision:<br>• 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; or<br>• 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 Pre-service Decision | Formerly known as a pre-certification 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 Appendix.

**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 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

As per the State and CMS, Emergency Services are "inpatient and outpatient services covered under this Contract that are furnished by a Provider qualified to furnish such services and that are needed to evaluate or stabilize a Member's Emergency Medical Condition." The Commonwealth defines Emergency Medical Conditions as any condition that manifests itself by "acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance use) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child."

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 preauthorized.

### 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 not a 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**.

### Disagreements between Beacon and attending physician

For acute services, in the event that Beacon's physician adviser 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 Appendix 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. 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/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 prefers Providers to make requests via eServices, we will work with Providers who 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. 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 Appendix. Forms can be found at **www.beaconhs.com/providers.html**.

### Inpatient services

All inpatient services (including inpatient ECT) require telephonic prior authorization within 24 hours of admission. Providers should call Beacon at **1-855-765-9704** 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 **1-855-765-9704**. 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: REPORTABLE INCIDENTS**

| Adverse determination | Adverse incidents | Sentinel events |
|---|---|---|
| The facility clinician making the request needs the following information for a pre service review:<br>• Member's health plan identification number;<br>• Member's name, gender, date of birth, and city or town of residence;<br>• Admitting facility name and date of admission;<br>• DSM IV diagnosis: All five axes are appropriate; Axis I and Axis V are required. (A provisional diagnosis is acceptable);<br>• Description of precipitating event and current symptoms requiring inpatient psychiatric care;<br>• Medication history;<br>• Substance use history;<br>• Prior hospitalizations and psychiatric treatment;<br>• Member's and family's general medical and social history; and 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:<br>• Member's current diagnosis and treatment plan, including physician's orders, special procedures, and medications;<br>• Description of the Member's response to treatment since the last concurrent review;<br>• Member's current mental status, discharge plan, and discharge criteria, including actions taken to implement the discharge plan; and discharge criteria, including actions taken to implement the discharge plan;<br>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 post-service 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 advisor 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 advisor (for outpatient services only). All denial decisions are made by a Beacon physician or psychologist (for outpatient services only) advisor. 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 time frames

Beacon is required by the State, federal government and the NCQA 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, federal government or NCQA 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 Authorization for Inpatient Behavioral Health Emergencies | Expedited | Within 30 minutes | Within 30 minutes | Within 24 hours |
| Initial Authorization for Non-emergent Inpatient Behavioral Health Services | Expedited | Within 2 hours | Within 2 hours | Within 24 hours |
| Initial Authorization for Other Urgent Behavioral Health Services | Urgent | Within 72 hours | Within 72 hours | Within 72 hours |
| Initial Authorization for Non-urgent Behavioral Health Services | Standard | Within 10 calendar days | Within 10 calendar days | Within 10 calendar days |
| **Concurrent Review** | | | | |
| Continued Authorization for Inpatient and Other Urgent Behavioral Health Services | Urgent/Expedited | Within 24 hours | Within 24 hours | Within 3 calendar days |
| Continued Authorization for Non-urgent Behavioral Health Services | Non-urgent/Standard | Within 10 calendar days | Within 10 calendar days | Within 10 calendar days |
| **Post Service** | | | | |
| Continued Authorization for Inpatient and Other Urgent Behavioral Health Services | Non-urgent/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 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 physician advisor 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.html**

Click on "Tools" and enter the plan name, and then click "Claims"

**Writing:** Use the "Provider Claim Appeal Request Form" located in this Appendix 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 Strategies Humana Claims Department**
10200 Sunset Drive
Miami, FL 33173

### Member Grievance and Appeals

Members have the right to file a Grievance or Appeal. They also have the right to request a state hearing for Medicaid services once they have exhausted their Appeal rights. Please refer to Humana's Member Grievance and Appeals procedures for further information.

# 6. General claim policies

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

**Definition of "clean claim"**
A clean claim, as discussed in this 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 Appendix 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.

**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 fourteen (14) 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 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 HIPAA-compliant revenue, DSM, CPT, HCPCS and appropriate ICD 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 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 6-3 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 992XX 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's degree level | UK | Service provided on behalf of the client to someone other than the client collateral relationship |

| TABLE 6-1: MODIFIERS | | | |
|---|---|---|---|
| HIPAA modifier | Modifier description | HIPAA dodifier | Modifier dtescription |
| 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 992XX provided by a psychiatrist.) |
| HQ | Group setting | UD | Substance abuse service |

### Time limits for filing claims

Beacon 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

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.

**Note:** CSB's have 180-day timely filing limit.

# 7. Provider claims information

### 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 **www.beaconhealthstrategies.com/providers.html**

- Subsection 6 of the Behavioral Health Section of this Appendix
- 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.partnerships@beaconhs.com
- ediops.miami@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: **1-855-765-9704**

Hours of operation are 8:30 a.m. – 5:30 p.m. Monday – Friday

- Beacon's Main Telephone Numbers Provider Relations: **1-855-765-9704** EDI: **1-855-765-9704**

**TTY: 1-855-371-3939**

Fax: 1-855-765-9705

### 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 payer ID is 43324
- 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: | Time frame for receipt by | Other information |
|---|---|---|---|---|---|---|
| | EDI | eServices | IVR | | | |
| Member Eligibility Verification | Y | Y | Y | • Completing any claim transaction; and<br>• 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 | Y | Y | N | Previous claim was denied for any reason except timely filing | Within 180 days after the date on the EOB | • Claims denied for late filing may be resubmitted as reconsiderations<br>• Rec ID is required to indicate that claim is a resubmission |

## TABLE 7-1: CLAIM TRANSACTION OVERVIEW

| Transaction | Access on: | | | Applicable when: | Time frame for receipt by | Other information |
|---|---|---|---|---|---|---|
| | EDI | eServices | IVR | | | |
| 180-day Waiver* (Request for waiver of timely filing limit) | N | N | N | A claim being submitted for the first time will be received by Beacon after the original 60-day filing limit (180 days for CSBs), and must include evidence that one of the following conditions is met<br>• Provider is eligible for reimbursement retroactively; or<br>• Member was enrolled in the plan retroactively; or<br>• Services were authorized retroactively.<br>• 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 circumstances. A waiver request that presents a reason not listed here will result in a claim denial on a future EOB.<br>• A claim submitted beyond the filing limit that does not meet the above criteria may be submitted as reconsideration request.<br>• 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* | N | N | N | • Claim was paid to Provider in error; and<br>• Provider needs to return the entire paid amount to Beacon. | N/A | **Do NOT send a refund check to Beacon.** |

## TABLE 7-1: CLAIM TRANSACTION OVERVIEW

| Transaction | Access on: | | | Applicable when: | Time frame for receipt by | Other information |
|---|---|---|---|---|---|---|
| | EDI | eServices | IVR | | | |
| Request for adjustment (Corrected claims) | N | Y | Y | • The amount paid to Provider on a claim was incorrect.<br>• Adjustment may be requested to correct:<br>- Underpayment (positive request); or<br>- Overpayment (negative request). | • Positive request must be received by Beacon within 180 days from the date of original payment.<br>• No filing limit applies to negative requests. | • Do NOT send a refund check to Beacon.<br>• A Rec ID is required to indicate that the claim is an adjustment.<br>• Adjustments are reflected on a future EOB as recoupment of the previous (incorrect) amount and, if money is owed to the Provider, re-payment of the claim at the correct amount.<br>• If an adjustment appears on an EOB and is not correct, another adjustment request may be submitted based on the previous incorrect adjustment.<br>• 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 be denied 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 CMS and 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 Strategies
Humana Claims Department
10200 Sunset Drive
Miami, FL 33173

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 Strategies

**Claim Department/Waivers**
**10200 Sunset Drive**
**Miami, FL 33173**

### 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 requests 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 UB-04 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 Strategies**
**Claim Departments – Adjustment Requests**
**10200 Sunset Drive**
**Miami, FL 33173**

### 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. **Health plan member ID 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 as identified 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 11.

For information on Humana's Health, Safety, and Welfare Training, see Section I — General Provider Information, subsection 14.

For information on Humana's Fraud, Waste, and Abuse Training, see Section I — General Provider Information, subsection 13.

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 **1-855-765-9704** or visit us at **www.beaconhs.com/providers** and click on "Tools" for help in understanding how to access this required training.

## ATTACHMENT A: AUTHORIZATION GUIDELINES

All medically necessary services which are included in a Member's care plan will be authorized as part of the care plan development process. For example, if ICT is included in the Member's care plan, it will be authorized by the Beacon care manager and no additional authorization will be required unless there is a change to the care plan.

### Outpatient services

| Benefit/service | Authorization requirement | Other requirements |
|---|---|---|
| Individual | None | N/A |
| Psychiatric diagnostic interview with medical services | None | N/A |
| Psychiatric diagnostic evaluation | None | N/A |
| Injection | None | N/A |
| Behavioral health/SA | None | N/A |
| Group therapy | None | N/A |
| Medication management (E/M) | None | N/A |
| Family and couples therapy | None | N/A |
| Medication | None | N/A |
| Therapy with biofeedback or hypnosis | Prior authorization | N/A |
| Psychological testing | Prior authorization | N/A |
| Neuropsychological testing | Prior authorization | N/A |
| ECT | Prior authorization | N/A |
| Acupuncture detox | Prior authorization | N/A |

| Inpatient Services | | |
|---|---|---|
| Benefit/service | Authorization requirement | Authorization requirement |
| Inpatient hospitalization | Telephonic prior authorization | Telephonic continued stay required for all services except emergency room. |
| Crisis stabilization | Telephonic authorization after 72 hours | Telephonic continued stay required for all services except emergency room. |
| Observation | Telephonic authorization after 72 hours | Telephonic continued stay required for all services except emergency room. |
| Emergency room services | None | Telephonic continued stay required for all services except emergency room. |
| Day treatment and partial hospital program | Telephonic prior authorization | Services may be authorized as part of a member's care plan. |
| MH intensive outpatient | Telephonic prior authorization | Services may be authorized as part of a member's care plan. |
| Behavioral health skills training | Authorization required prior to fifth visit | Services may be authorized as part of a member's care plan. |
| Psychosocial rehab (PSR) | Authorization required after 180 units combined provided | Services may be authorized as part of a member's care plan. |
| Medication training | Authorization required after 180 units combined provided | Services may be authorized as part of a member's care plan. |
| Medication monitoring | Authorization required after 180 units combined provided | Services may be authorized as part of a member's care plan. |
| Intensive community treatment | Prior authorization | Services may be authorized as part of a member's care plan. |
| Crisis intervention | None | Services may be authorized as part of a member's care plan. |

| Substance abuse treatment services | | |
|---|---|---|
| Benefit/service | Authorization requirement | Authorization requirement |
| SA residential treatment for pregnant women | Telephonic prior authorization | N/A |
| Substance abuse day treatment | Telephonic prior authorization | N/A |
| Substance abuse care treatment | Telephonic prior authorization | N/A |
| Substance abuse intensive outpatient | Telephonic prior authorization | N/A |
| Substance abuse crisis intervention | No prior authorization required | N/A |
| Opioid replacement therapy | No prior authorization required | N/A |

## ATTACHMENT B: DETAILS OF STATE DEMONSTRATION AREA

Humana covers behavioral health and substance use services via Beacon to Members in five regions: Central Virginia, Northern Virginia, Tidewater, Western/Charlottesville and Roanoke. The localities that make up each region are listed below.

| Central Virginia | | Northern Virginia | Tidewater | Roanoke |
|---|---|---|---|---|
| Amelia | Prince George | Arlington | Gloucester | Alleghany |
| Brunswick | Richmond Co. | Culpeper | Isle Of Wight | Bath |
| Caroline | Southampton | Fairfax County | James City County | Bedford County |
| Charles City | Spotsylvania | Fauquier | Mathews | Botetourt |
| Chesterfield | Stafford | Loudoun | Northampton (Optional*) | Craig |
| Cumberland | Surry | Prince William | York | Floyd |
| Dinwiddie | Sussex | Alexandria | Chesapeake | Franklin County |
| Essex | Westmoreland | Fairfax City | Hampton | Giles |
| Goochland | Colonial Heights | Falls Church | Newport News | Henry |
| Greensville | Emporia | City of Manassas | Norfolk | Highland |
| Hanover | Franklin City | Manassas Park | Gloucester | Montgomery |
| Henrico | Fredericksburg | Western/ Charlottesville | Isle Of Wight | Patrick |
| King and Queen | Hopewell | Albemarle | James City County | Pulaski |
| King George | Petersburg | Augusta | Mathews | Roanoke County |
| King William | Richmond City | Buckingham | Northampton (Optional*) | Rockbridge |
| Lancaster | | Fluvanna | York | Wythe |
| Lunenburg | | Greene | Chesapeake | Bedford City |
| Mecklenburg | | Louisa | Hampton | Buena Vista |
| Middlesex | | Madison | Newport News | Covington |
| New Kent | | Nelson | Norfolk | Lexington |
| Northumberland | | Orange | Poquoson | Martinsville |
| Nottoway | | Rockingham | Portsmouth | Radford |
| Powhatan | | Charlottesville | Suffolk | Roanoke City |
| Prince Edward | | Harrisonburg | Virginia Beach | Salem |
| | | | Williamsburg | |

*__Note:__ As per the State, plans have the option to participate in these areas. Currently, Humana provides coverage to both optional localities. However, this may change in the future.

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