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CHAPTER 1: INTRODUCTION

ABOUT HUMANA BEHAVIORAL HEALTH INC.

Humana Behavioral Health Inc. (hereinafter referred to as "HBH"), a wholly owned subsidiary of Humana Inc., provides behavioral health solutions through a national network of behavioral health providers, managed behavioral health care and integrated medical behavioral health care.

Humana's specialty behavioral network includes more than 65,000 fully credentialed providers and over 1,700 facilities nationwide.

Humana has a full three-year accreditation from the National Committee for Quality Assurance (NCQA) for Managed Behavioral Healthcare Organization.

CORPORATE PHILOSOPHY

The Humana Inc. system assumes that mental/behavioral illness is similar to other illnesses, in that it is the result of the interaction of biochemical, psychological and social stressors that result in various degrees of disability or impairment in functioning. Mental wellness/illness is a dynamic balance that is rarely at one end or the other of the continuum for extended periods of time. The goal of treatment is to decrease the frequency, intensity and duration of mental/behavioral impairment that results from these biopsychosocial stressors. Science-based treatments and providers skilled in these treatments are identified. Treatment should be provided in the least restrictive manner and focus on maximizing the enrollee's degree of freedom to choose treatment options and participate in identifying the goals of treatment. Enrollee responsibility to recovery and wellness is encouraged at all levels throughout the episode of care.

CORPORATE STATEMENTS

Mission

Changing behaviors, improving lives

Vision

Humana transforms experiences through leading integrated solutions to optimize:

- Health and well-being
- Personal and workplace productivity
- Health resources

PURPOSE OF THIS MANUAL

Humana Behavioral Health's provider manual is an extension of the participation agreement between Humana Behavioral Health and all provider types including, but not limited to, providers, physicians, hospitals, and facilities ("provider[s]") and furnishes such providers and their office staff with information concerning policies and procedures, claims, and guidelines used to administer the

HBH network. This manual replaces and supersedes the previous version dated June 2011 and is available on www.humanabehavioralhealth.com. A paper copy may be obtained upon written request.

In accordance with the **Policies and Procedures** clause of the participation agreement, providers must abide by all provisions contained in this manual, as applicable. Revisions to the manual constitute revisions to Humana's policies and procedures. Revisions shall become binding ninety (90) days after notice is provided by mail or electronic means, or such other period of time as necessary for HBH to comply with any statutory, regulatory and/or accreditations requirements.

To comply with the **Policies and Procedures** clause of the participation agreement, please obtain a provider manual for each Payor to this network to determine which policies and procedures are applicable to each Payor.

As policies and procedures change, updates will be issued and will be incorporated into subsequent versions of this manual. Any change in policies and procedures must be implemented according to the time frame in the participation agreement. Updates that are state specific may override the policies and procedures in this manual.

RESPONSIBILITY FOR PROVISION OF MEDICAL SERVICES

Providers are independent contractors. This means providers and HBH do not have an employer-employee, principal-agent, partnership, joint venture or similar arrangement. It also means that providers make all independent health care treatment decisions. Additionally, providers are responsible for the costs, damages, claims and liabilities that result from their own actions. HBH does not endorse or control the clinical judgment or treatment recommendations made by providers.

Payors may require preauthorization with respect to some services and procedures. HBH administers the prior authorization requirements for the purpose of determining whether the services or procedures qualify for payment under the member's benefit plan. Providers, along with the member, make the decision whether the services or procedures are provided.

QUESTIONS OR COMMENTS

Questions or comments about the policies and procedures in the manual should be directed to HBH Provider Relations at the address or phone number listed below:

Humana Behavioral Health
Provider Relations Department
2101 W. John Carpenter Freeway
Irving, TX 75063

Telephone: 1-800-890-8288
Fax: 1-866-662-9683

Email: behavioralhealthproviderservices@humana.com

CHAPTER 2: CONTRACT INFORMATION

ADDRESS CHANGE OR OTHER PRACTICE INFORMATION

In order for HBH and Payor to maintain accurate participating provider directories and also for reimbursement purposes, all changes to address or other practice information should be submitted electronically via www.humanabehavioralhealth.com or reported in writing as soon as possible to the HBH corporate office. Notices of changes must adhere to time frames outlined in the participation agreement.

Changes that require notice may include, but are not limited to, the following:

- Provider information
- Tax identification number (TIN)*
- National Provider Indicator (NPI)
- Address
- Phone number
- Practice name
- Addition of a provider – provider joining practice/group**
- Provider deletion – provider no longer participating with practice/group
- Medicare number

Providers also should notify Humana Behavioral Health if the provider is no longer accepting new patients.

* Changes in tax ID numbers may require an amendment or new participation agreement depending on the reason for the change. Check with a provider representative at the corporate office for specific information.

** If adding a provider, the new provider must first be credentialed before rendering treatment to any plan member.

CONTACT US

Member Eligibility Inquiries

- Visit: Payor website listed on member's insurance card, humanabehavioralhealth.com; or
- Telephone: Toll-free number on member insurance card or 1-800-777-6330

Note: A copy of the Medicare enrollment form may serve as verification of eligibility for Medicare members who have not received their member ID card at the time of service. Members may not be denied services.

Humana's verification does not guarantee payment. If Humana subsequently learns that the member was ineligible on the date of verification, no payment will be made. Therefore, it is important that providers always ask a patient for his or her most recent insurance status.

Preauthorization and Notification
Visit humanabehavioralhealth.com or call 1-800-777-6330.

Provider Relations
Telephone: 1-800-890-8288; Fax: 1-866-662-9683
Email: behavioralhealthproviderservices@humana.com

The Provider Relations Department is available to assist you during normal business hours, 7:30 a.m. to 5 p.m., Central Time, Monday through Friday, excluding holidays.

Humana Customer Service
Call 1-800-777-6330 or call the number listed on the back of the member's ID card. Contact Humana customer service for assistance with questions regarding:

- Benefits
- Claims
- Grievance and/or appeals
- Eligibility
- Utilization Management

Concurrent Review/Discharge Planning
1-800-777-6330

HUMANABEHAVIORALHEALTH.COM

Network providers may log on to humanabehavioralhealth.com for administrative and informational needs pertaining to HBH. The unsecured section of Humana Behavioral Health's site offers a variety of information resources and links to clinical practice guidelines. The secured section of the site features transactional capabilities related to member eligibility and benefits, authorization inquiry, claims submission and clinical forms.

humanabehavioralhealth.com - Unsecured Provider Section - (no registration required)

- **Clinical and Healthcare Resources:** Quickly locate details about HBH's clinical practice guidelines and resources, and patient health education.

- **Commonly used Provider forms:** Provider address change, utilization management, coordination of care, medication management, outpatient therapy (initial, concurrent, extended), and neuropsychological testing request forms are available.

- **Utilization Management Information:** Find information, standards and policies for the Humana utilization management processes.

- **Health Insurance Portability and Accountability Act of 1996 (HIPAA):** Find information on HBH's commitment to protecting confidential information about members and their health as well as details and access to the HIPAA patient consent to release information form.

- **Treatment Records:** Learn more about the Humana guidelines for treatment record documentation, standards for availability of treatment records and performance goals to define expectations for providers.

- **Publications and Resources:** Find the latest editions of the Humana Behavioral Health Provider Manual, provider newsletter, The Navigator, and other resources on various health issues.

CHAPTER 3: NETWORK OVERVIEW

LIABILITY INSURANCE

Providers should maintain their own insurance to protect themselves and their employees against any claim resulting from the provision of health care services. This coverage should include, but is not limited to, professional liability insurance in the amounts as required by their participation agreement or applicable state law, whichever is greater.

Upon request, all providers shall provide HBH with evidence of insurance coverage in accordance with their participation agreement requirements.

CREDENTIALING

Humana conducts initial credentialing prior to contracting with a provider and recredentialing for behavioral health care providers every three (3) years, or sooner if necessary. The credentialing and recredentialing process includes source verification consistent with industry standards. On-site provider office and facility administrative audits may be performed as part of the initial credentialing and recredentialing process for high-volume providers, including a medical record review. Providers who have received adverse actions or malpractice suits will be reviewed extensively for approval as a network provider through the Credentialing Committee. Humana will be responsible for tracking the provider's sanctions restrictions on licensure and limitations on scope of practice, Medicare and Medicaid sanctions and exclusions on an ongoing basis. Humana may use a Credentials Verification Organization (CVO) to assist with source verification.

After the completion of primary or accreditation approved source verification, the Humana Credentialing Committee reviews the provider's file and ensures that all documentation is in compliance with the credentialing standards. For recredentialing, the Humana Credentialing Committee reviews the provider's credentialing file along with network performance data from the previous three (3) years. The Humana Credentialing Committee makes the final determination about the credentialing and recredentialing status of providers. For recredentialing applications, the provider is considered to be recredentialed unless otherwise notified. Providers wishing to appeal a credentialing decision may submit a written appeal to:

Humana Credentialing Department
12501 Lakefront Place
Louisville, KY 40299

Prior to contracting with a hospital, Humana confirms that the facility has met minimum criteria, including, but not limited to: Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and/or Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation certificates and accompanying award letters from the accrediting organizations; Confirmation that the provider is in good standing with state and federal regulatory bodies [e.g., state license, Medicare/Medicaid intermediaries, Office of Inspector General's (OIG) and General Services Administration (GSA)] and/or certified by Medicare; federal Drug Enforcement Administration (DEA) certificate; malpractice policy insurance cover page; and a current roster of admitting psychiatrists and addictionologists.

Humana maintains a provider file with each provider's credentials, source verification and executed Humana provider agreement with attachments, as applicable.

Humana has adopted the following credentialing standards for network providers:

- MA, MSN, MS, MEd or doctoral level licensure in Social Work, Counseling, Marriage & Family Therapy, Psychology, MD/DO Psychiatrists, Nurses with a behavioral health state or national certification, and Addiction Medicine Physicians
- Highest level of applicable licensure offered by the state in which they practice
- Malpractice insurance coverage

PROVIDER SELECTION CRITERIA

Providers must meet established criteria in order to participate in Humana's provider network. Humana's criterion includes the quality of care and service that the provider delivers and Humana's current business needs. You can reference the following for more information regarding the criteria:

- Quality of care – Chapters 10 and the Appendix in this Provider Manual
- Humana's business needs – "Join our Network" on humanabehavioralhealth.com for current needs and open enrollment periods

FRAUD, WASTE AND ABUSE POLICY**:**

Humana should be notified immediately if a provider or the provider's office staff:

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

Providers may provide the above information via an anonymous phone call to Humana's Fraud Hotline at 1-800-614-4126. All information will be kept confidential. Entities are protected from

retaliation against callers because Humana has a zero tolerance policy for retaliation or retribution against any person who reports suspected misconduct.

Humana's Special Investigations Unit (SIU) is responsible for detecting, investigating and preventing fraud, waste and abuse (FWA). The SIU reviews all allegations received through the Fraud Hotline and other referral sources to determine if fraudulent activity has occurred. Credible allegations of fraud, waste and abuse related to any Medicare program are referred to CMS National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) in accordance with CMS regulations. Referrals to other government agencies and law enforcement are also made when appropriate based on the line of business, state and referral requirements. The following link is available on Humana.com and will provide additional information for reporting FWA:

https://www.humana.com/about/legal/disclaimer-and-licensure/fraud-waste-and-abuse

SIU refers cases to the appropriate law enforcement and/or regulatory agencies in accordance with applicable regulations and requirements.

REPORTING OCCURRENCES:

Providers are expected to report any occurrence that happens to a member when visiting their offices. Occurrences inside an inpatient facility or treatment center are dictated by operational procedures of each facility. An occurrence is defined as any unforeseen complication or unusual event in which a member is involved. Examples of occurrences are:

- Unexpected death at the member's home, office, or public place, particularly after a recent office visit
- Complication of drug, treatment, or service prescribed
- Breach of confidentiality
- Requests for medical records by an attorney

Report all occurrences to Humana as soon as possible, preferably within 14 days of the occurrence.

CONFLICTS OF INTEREST

Providers are prohibited from having any financial relationship relating to the delivery of or billing for covered services that:

- Would violate the federal Stark Law, 42 U.S.C. § 1395nn, if health care services delivered in connection with the relationship were billed to a federal health care program; or that would violate comparable state law;
- Would violate the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, if health care services delivered in connection with the relationship were billed to a federal health care program; or that would violate comparable state law; or in the judgment of Humana could reasonably be expected to influence provider to utilize or bill for covered services in a manner that is inconsistent with professional standards or norms in the local community.

Providers are subject to termination by Humana for violating this prohibition. Humana reserves the right to request such information and data as it may require ascertaining ongoing compliance with these provisions.

ACCESS STANDARDS

In order to comply with the requirements of CMS, accrediting and regulatory agencies, Humana has adopted certain standards for participating providers, which are summarized below. The purpose of these standards is to ensure that services are available and accessible to members.

- Coverage 24 hours a day, seven (7) days a week
- Care for life-threatening emergency within one (1) hour or immediately
- Care for non-life-threatening emergency within six (6) hours
- Urgent appointments for Medicare members within 24 hours
- Urgent appointments for commercial members within 48 hours
- Routine appointments within 10 business days

Services are generally considered accessible if they reflect usual practice and travel arrangements in the local area. For Medicare/Medicaid accounts, provider services should be available within 20 to 110 minutes or 10 to 100 miles, depending on the type of region. Commercial standards follow a similar pattern. Generally, the less populated an area is, the longer the distance and time frame allocated for the member to reach a behavioral health practitioner.

OPEN COMMUNICATIONS

Providers are encouraged to communicate openly with members regarding appropriate treatment alternatives regardless of benefit limitations. Humana shall not terminate, reduce Provider's referrals, or otherwise penalize a provider for discussing treatment alternatives, medical necessity of treatments, or appropriate care for a member.

EXPECTATIONS FOR IN-OFFICE APPOINTMENT WAIT TIMES

Ideally, every scheduled, in-office appointment would begin on time, but that is not always possible. Many things come up that can disrupt even the most careful planning. While shorter wait times are better, Humana's expectation is that average in-office wait time should not exceed 15 minutes from the time of the patient's scheduled appointment. In the case of an unexpected emergency that may cause this standard to be exceeded, the member should be notified and given the option of waiting or rescheduling. Your cooperation in striving to meet or improve upon this goal is greatly appreciated. Humana may monitor compliance with the access standards through a variety of ways, including audits during site surveys, telephone audits, member surveys and complaints.

Note: State regulations, if more stringent, may take precedence over these time frames.

HOME OFFICE PRACTICES

Humana network provider offices based in a home or in a dwelling that was once a residential home must present a professional image and be comparable to a commercial office setting. It is

expected that full disclosure of the practice in the provider's home must be made to the Humana's payor's members prior to scheduling an appointment. Additionally, the provider's malpractice insurance carrier must be notified that the visits are taking place in a home-office setting.

A practice based in the provider's home must have the following:

a. Private entrance and exit separate from the entrance to the home
b. Private restroom dedicated to the office
c. A private waiting area inside the home away from the living quarters
d. Separation from the living quarters of the home and have adequate sound barrier
e. Adequate parking
f. Adequate lighting
g. Appropriate signage
h. No animals in the practice office
i. Liability coverage in home owner's insurance

Providers may office in a building that was formerly a residential home but is currently zoned as commercial. In this instance, the structure must have adequate parking, lighting, signage and sound barriers.

Any home-based office or office in a former dwelling must comply with community and professional standards, state laws, licensing board regulations and code of ethics. Humana Network Operations or Quality Improvement representatives may visit a home-based practice or practice located in a former dwelling to ensure the location meets these standards and expectations.

CHAPTER 4: RIGHTS AND RESPONSIBILITIES

PROVIDERS' RIGHTS AND RESPONSIBILITIES

In order to comply with the requirements of accrediting and regulatory agencies, Humana has adopted certain rules for participating providers that are summarized below. This is not a comprehensive, all-inclusive list. Additional responsibilities are presented elsewhere in this manual and the participation agreement.

Providers have the responsibility to:

- Have a professional degree and a current, unrestricted license to practice in the state in which provider services are regularly performed.
- Be credentialed by Humana as required.
- Provide documentation on his/her experience, background, training, ability, malpractice claims history, disciplinary actions, sanctions and, physical and mental health status for credentialing purposes.
- Possess a current, unrestricted DEA certificate and/or a state Controlled Dangerous Substance (CDS) certificate or license, if applicable.

- Be a medical staff member in good standing with a participating network hospital(s), if he/she makes member rounds, and have no record of hospital privileges having been reduced, denied or limited; or, if so, provide an explanation that is acceptable to Humana.
- Notify Humana in writing within 24 hours of any revocation or suspension of his/her Bureau of Narcotics and Dangerous Drugs number, and/or of suspension, limitation, or revocation of his/her license, reduction and/or denial of hospital privileges, certification, or other legal credential authorizing him/her to practice in the state.
- Notify Humana immediately of changes in licensure status, TIN, NPI, telephone numbers, addresses, status at participating hospitals, provider status (additions or deletions from provider practice), loss or decrease in amounts of liability insurance, and any other change that would affect his/her status with Humana.
- Not discriminate based on a member's health status.
- Not discriminate in any manner between Humana's payor members and non-payor's members.
- Inform members regarding follow-up care or provide training in self-care as required by CMS.
- Make services available and accessible to members 24 hours per day, seven (7) days per week, 365 days per year, and in a manner that ensures continuity of care.
- Refer Humana's payor members with problems outside of his/her normal scope of practice for consultation and/or care to appropriate specialists contracted with Humana and/or Payor Plan on a timely basis.
- Admit members only to participating network hospitals and other inpatient care facilities, except in an emergency, and/or work with the hospital-based physicians in possible cases of need for acute hospital care.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Humana's payor member for rendered services other than for applicable copayments or fees for non-covered services furnished on a fee-for-service basis. Non-covered services are services not covered by Medicare or services excluded in the member's evidence of coverage or certificate of coverage.
- Provide services in a culturally competent manner, i.e., removing all language barriers. Care and services should accommodate the special needs of ethnic, cultural, and social circumstances of the patient.
- Provide access to health care benefits for all plan members, and be consistent with CMS requirements for Medicare Advantage members.
- Provide or arrange for all members to have continued treatment, including, but not limited to, medication therapy, upon expiration or termination of the participation agreement.
- Retain all agreements, books, documents, papers, and medical records related to the provision of services to members as required by state and federal laws.
- Treat all member records and information confidentially, and not release such information without the written consent of the member, except as indicated herein, or as needed for compliance with state and federal laws, including HIPAA, as well as Humana treatment record policies.
- Transfer copies of treatment records to other Humana or Plan providers upon request and at no charge to Humana, the member, or the requesting party, unless otherwise agreed upon.

- Provide access and opportunity for Humana or its designee to examine the provider's office books, records, and operations of any related organization or entity. A related organization or entity is defined as having:
    - Influence, ownership or control, and
    - Either a financial relationship or a relationship for rendering services to the primary care office. The purpose of this access is to help guarantee compliance with all financial, operational, quality assurance, and peer review obligations, as well as any other provider obligations stated in the participation agreement with Humana or in this manual. Failure by any person or entity involved, including the provider, to comply with any requests for access within ten (10) business days of receipt of notification will be considered a breach of contract. For records related to Medicare Advantage enrollees, this access right is for the time stipulated in the provider participation agreement or the time period since the last audit, whichever is later.
- Comply with Humana's quality improvement and utilization management policies and procedures.
- Adhere to Member Rights and Responsibilities statement.
- Comply with record standards, reviews and site visits.
- Meet the requirements of all applicable state and federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.
- Agree to cooperate with Humana and/or Plan in its efforts to monitor compliance with its Medicare Advantage agreement(s) and/or Medicare Advantage rules and regulations, and assist Humana and/or Plan in complying with corrective action plans necessary for Humana and Plan to comply with such rules and regulations.
- Notify Humana of any material change in provider's performance of delegated functions, if applicable.
- Notify Humana of his/her termination in a timely manner prior to the effective date of termination.
- Maintain full participation status in the Medicare program, and/or not be excluded from participating in the program while providing services to Medicare Advantage members.
- Cooperate with an independent review organization's activities pertaining to the provision of services for commercial members and Medicare members in a Medicare Advantage plan.
- Respond expeditiously to Humana's request for treatment records or any other documents in order to comply with regulatory requirements, and to provide any additional information about a case in which a member has filed a grievance or appeal.
- Understand and agree that nothing contained in the participation agreement or this manual is intended to interfere with or hinder communications between providers and members regarding a member's medical condition or available treatment options or to dictate medical judgment.
- Providers who have downstream agreement(s) with physicians or other providers who provide services to Humana's payor members agree to provide a copy of said agreement(s) to Humana upon request (financial information will not be requested)

Providers have the right to:

- File a grievance or appeal with respect to the performance or interpretation of the Provider Agreement.
- Appeal when Humana takes action for quality issues.
- Receive a response to questions or concerns in a prompt and professional manner.
- Receive information concerning Humana's grievance and appeal procedures, Provider Manual, utilization and quality improvement policies.
- Receive verification of covered member eligibility.
- Request a roster of participating providers.
- Correct any erroneous information and appeal any decision during the primary verification of provider credentials or the recredentialing process.
- Upon request, be informed of the status of the recredentialing application.

MEMBERS' RIGHTS AND RESPONSIBILITIES

Humana adheres to certain rules of accrediting and regulatory agencies concerning member rights. Humana's members have certain rights and responsibilities when being treated by HBH contracted providers. The rights and responsibilities statement reminds members and providers of their complementary roles in maintaining a productive relationship.

The Member Rights and Responsibilities statement is available on humanabehavioralhealth.com.

CHAPTER 5: CLAIMS PROCEDURES

VERIFICATION OF MEMBER BENEFITS AND ELIGIBILITY

The provider is responsible for verifying the patient's benefits, eligibility, deductibles, and copayments. Benefits can be obtained by calling the number for mental health services on the back of the patient's insurance card. If the card does not include the mental health services phone number, you may call our customer service line at 1-800-777-6330 or visit the secured provider self-service area on humanabehavioralhealth.com.

For Medicare enrollees, a copy of the Medicare enrollment form may serve as verification of eligibility for Medicare members who have not received an ID card at the time of service.

PREAUTHORIZATION AND NOTIFICATION

Providers must determine whether preauthorization or notification is required with respect to services rendered to any Humana member. To make this determination, providers must call the behavioral health management number on the back of the member's ID card or call Humana at 1-800-777-6330. Providers may also visit humanabehavioralhealth.com.

(**Note**: Precertification, preadmission, preauthorization and notification requirements all refer to the same process of preauthorization.)

For hospital admission, the provider must access humanabehavioralhealth.com or call the number listed on the back of the member's ID card. For urgent authorizations or notifications, call 1-800-777-6330 and ask for the clinical department.

- **Concurrent Review:** Concurrent review is the process that determines coverage during the facility based stay. *It is the Provider's responsibility to contact Humana within **24 hours** of an admission. If contact with Humana is not made, the review of the member's care will be retrospective or has the potential to be denied.* Additional instructions and information regarding concurrent review is also found in Chapter 10 of this provider manual.

- **Retrospective Review:** Retrospective review consists of a clinical review for a service that requires authorization when no authorization is on file. This may include when an authorization on file does not cover all dates of service on the claim or when claims for the dates of service do not match previously obtained authorization. Following the normal claim filing procedure, the provider must submit the claim to Humana. If it is determined medical records are required to process the claim, the provider will receive a letter advising of the documentation required for review and directions for how to submit the required information.

- **Clinical Practice Guidelines:** The clinical practice guidelines are available in Chapter 9 and on humanabehavioralhealth.com.

CLAIMS SUBMISSION AND PROCESSING

HBH strongly recommends that all claims not requiring paper attachments be submitted via electronic means. Internet-based claims submission is available at no charge to the provider for HBH's payor member claims.

INSURANCE CLAIM FORMS

Providers shall submit all claims to Humana, as applicable, using the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") compliant 837 electronic format or a CMS 1500 and/or UB-04, or their successors. Humana or payor may, in its sole discretion, deny payment for any claim(s) received by Humana after the later of 90 days from the date of service or the time specified by applicable state law. Provider acknowledges and agrees that at no time shall members be responsible for any payments to provider except for applicable copayments and non-covered services provided to such members.

The member will be notified of all payments made by Humana or payor to participating providers with an Explanation of Benefits (EOB) statement. If a claim is pended for review, a letter communicating such will be sent to the provider.

If services are not authorized by HBH or Payor, claims may be pended. HBH or Payor's medical management may require either a telephone call, electronic submission of required information or written documentation from the provider.

Completed forms must include the following information:

- Assignment of benefits (signed)
- Certification number*
- CPT or revenue code
- Date(s) of service
- Diagnosis code
- Employer's insurance company
- Insured's employer
- Insured's name
- Insured's Social Security or member number
- Other insurance information
- Patient's name
- Patient's date of birth
- Provider's tax ID number
- Provider's retail rate
- Release of information (signed)

*Certification number

In most cases, an HBH associate or an HBH affiliate provider will refer a member to a provider for services. In addition to a telephone contact, the HBH associate creates an authorization for the provider, which generates an authorization letter indicating the following: the certification/authorization number, the CPT service code, the number of units, and the effective dates of the certification. Care rendered outside of the effective dates of certification will result in a denial of claims submitted. Certification is not a guarantee of claims payment or benefit eligibility. Final determination is made at the time claims are processed.

All claims for inpatient treatment must include an inpatient authorization/certification number. For Medicare members, prior authorization does not need to be obtained for emergency or urgent care, regardless of whether the services are obtained within or outside the MA organization's provider network.

The certification number, supplied in the upper right corner of the "notification of certification" letter, should be included on all HCFA 1500 or UB-92 claim forms submitted to Humana. When submitting claims on the HCFA 1500 form, list the certification number on line 23 (Prior Authorization Number) or section K (Reserved for Local Use) fields. On the HCFA 1450 (UB-92) form, list the certification number in Section 63 (Treatment Authorization Codes). Mail claims to the address indicated on the "notification of certification" letter.

Preprinted HCFA forms are available through most major office supply stores, major printing companies, and the Centers for Medicare & Medicaid Services at www.cms.gov.

PAYMENT OF CLAIMS

A claim is processed promptly if it is approved or denied within the time required by the participation agreement or the applicable regulation of the state in which Humana or Payor is operating. For claims to be paid promptly:

- A complete and accurate claim (a "clean claim" is one submitted electronically or by paper that does not involve outreach to obtain additional information necessary to process the claim of an investigation for coordination of benefits (COB), pre-existing condition investigation, member eligibility, or subrogation).

- A member's original signature **or** "Signature on File" or "Assignment on File" stamp is required for payments made directly to the provider.

  Note: The provider must maintain a valid written assignment of benefits from the member on file. This will serve as evidence that the provider is entitled to all payments for service. Humana reserves the right to review the original signed assignment document at any time.

- Separate charges must be itemized on separate lines. Medical record documentation must validate the scope of services provided and billed.

- Time frame for submitting claims:

  - **Commercial:** claims must be submitted within ninety (90) days from the date of service or within the time frame specified by applicable state law to Humana or Payor. Refer to participation agreement for specific time frames.

  - **Medicare:** claims must be submitted within 12 months. Effective January, 1, 2011, CMS requires a timely filing deadline of 12 months. The one-year filing date will be counted for physicians and suppliers based on the "From" date. Processing staff are to split the line item and deny untimely services if the "From" date is not timely but the "To" date is. Institutional claims will be based on the "Through" date timely determination.

All claims for covered services must be submitted within the required time frames or the claim may be denied. All claims submissions are considered final unless reconsideration requests are made in writing within 60 days after receipt of the Explanation of Payment. Claims denied due to untimely filing may not be billed to the patient.

Requests for Review of Denied Claims: Providers may request a review of service or claim payment denials by the plan(s). To obtain a review or for assistance with other claims issues, providers should call Humana Customer Service.

Coding Edits: Humana will process provider claims that are accurate and complete in accordance with Humana's normal claims processing procedures and applicable state and/or federal laws, rules and regulations with respect to the timeliness of claims processing. Such claims processing procedures and edits may include, without limitation, automated systems applications which identify, analyze and compare the amounts claimed for payment with the diagnosis codes and which analyze the relationships among the billing codes used to represent the services provided to members. These automated systems may result in an adjustment of the payment to the provider for the services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by

these automated systems by submitting a timely request for reconsideration to Humana. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

REIMBURSEMENT

Payment terms are defined in the participation agreement. The amount of payment for services provided is affected not only by the terms in the participation agreement, but also by the following:

- Member's eligibility at the time of service
- Whether services provided are covered services under the member's plan
- Whether services provided are medically necessary as required by the member's plan
- Whether services were without the prior approval of HBH, if prior approval is required by the member's plan
- Amount of the provider's billed charges
- Member copayments, coinsurance, deductibles, and other cost-share amounts due from the member and coordination of benefits with third-party payors as applicable
- Adjustments of payments based on coding edits described above
- Humana payment policies

A provider who receives reimbursement for services rendered to Humana's Medicare Advantage members must comply with all federal laws, rules, and regulations applicable to individuals and entities receiving federal funds, including, without limitation, Title VI of the Civil Rights Act of 1964, Age Discrimination Act of 1975, Americans with Disability Act, and Rehabilitation Act of 1973.

Nothing contained in the participation agreement or this manual is intended by HBH or Payor to be a financial incentive or payment which directly or indirectly acts as an inducement for providers to limit medically necessary services.

Providers shall accept payment for Humana and/or payor for covered services provided to members in accordance with the reimbursement terms outlined in the participation agreement. Payments made to providers constitute payment in full by Humana and/or payor for covered benefits, except with respect to copayments, coinsurance and deductibles, which are the member's responsibility. These payments made by Humana and/or Payor are net of member copayments, coinsurance and deductibles. For covered services, providers may not balance bill members for a monetary amount over or above the fee schedule provided in their participation agreement; however, they are not prohibited by the participation agreement from collecting from members for any services not covered under the terms of the applicable member plan. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

Services that are not medically necessary: The Provider agrees that, in the event of a denial of payment for services rendered to members determined not to be medically necessary by HBH or member plan, the provider shall not bill, charge, seek payment or have any recourse against member for such services.

Facility reimbursement only: The Facility agrees to comply with Humana's or payor's audit policy. Copies are available upon request by contacting Humana or payor.

CHAPTER 6: CLINICAL SERVICES

The Humana Behavioral Health Clinical Department is staffed by health care professionals with a wide range of disciplines and experience in the behavioral health care field. The clinical associates, clinical managers, and director of Clinical Services all possess current, valid and unrestricted licenses in the state in which they reside and include:

- Licensed Professional Counselor (LPC),
- Licensed Master's Social Worker (LMSW and LCSW),
- Licensed Marriage and Family Therapist (LMFT),
- Licensed Psychologist (PhD/EdD)
- Registered Nurse (RN)

Humana Behavioral Health utilizes board-certified, licensed psychiatrists in making utilization review decisions.

The clinical department is composed of a clinical intake team, three divisional teams that provide care management and utilization management services, an aftercare follow-up (AFU) team, a co-management team, a specialty team, and a clinical claims review team.

Clinical Intake Team

The clinical intake team completes all admission certifications for facility based care, including inpatient psychiatric and detox, residential treatment (RTC), partial hospital program (PHP), intensive outpatient programming (IOP) and outpatient treatment visits.

Divisional Concurrent Review Teams

The divisional concurrent review teams complete all concurrent reviews for facility based care, ensure the development and implementation of quality treatment and discharge planning and refer members to care management upon discharge from facility based care.

Aftercare Follow-up Team

The AFU team outreaches to all members discharging home from inpatient treatment. They also provide education on the importance of treatment compliance, remind members of aftercare appointments with outpatient providers, resolve barriers to the member keeping the aftercare appointment, assist members with provider referrals or special provider searches when needed and assist with aftercare appointments for members with behavioral health issues but being treated in an inpatient medical facility, to ensure behavioral health appointments are included in the discharge plan.

Co-management Team

The co-management team collaborates regularly with involved medical counterpart care managers for members who have co-occurring behavioral health and physical health needs. They educate members on behavioral health symptoms and treatment options, coordinate

access to behavioral health providers, address barriers to accessing behavioral health treatment, assist in member access and education regarding prescribed behavioral health treatments, and assist in coordination of behavioral health treatment within a member's larger treatment team and support network.

Specialty Team

The specialty team authorizes and manages care for members who have an Autism, Eating Disorder or Post-Traumatic Stress Disorder diagnosis. The team provides care management services to those same members.

Clinical Claims Review Team

The clinical claims review team is responsible for completing utilization reviews on cases where the member was treated in facility based care and was discharged, but the facility did not notify Humana Behavioral Health for an authorization at admission. The team also reviews the medical records from the treatment stay for medical necessity.

CHAPTER 7: GRIEVANCE/APPEALS PROCESS

The grievance/appeal process applies to members of individual plans, commercial group plans and Medicare Advantage (MA) members who are dissatisfied with the health care services received, or any aspect of the plan. A grievance/appeal may be filed by an enrollee or his/her authorized representative. Providers may file on behalf of the member by obtaining authorization from the member unless otherwise allowed by state regulations. Also, certain states and federal programs may have a specific process for provider grievance/appeal requests. The grievance process is intended to resolve complaints or disputes, other than initial determinations or reconsiderations, when an expression of dissatisfaction is formalized in writing. The appeal process evaluates an adverse or organizational determination. If the initial grievance/appeal is upheld, the resolution letter will provide next level rights as applicable. Expressed

DEFINITIONS/EXPLANATIONS

ADVERSE DETERMINATION: A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a benefit:

- In whole or part for a benefit
- Based on eligibility to participate in the plan (when a claim or appeal is made)
- Based on rescission of coverage

COMMERCIAL APPEALS: There are two types of appeals:

- **Contractual:** Requested services do not meet the requirements of the member's health plan or services are excluded from the plan.
- **Medical necessity:** Certification is denied because the services being requested do not meet Humana's clinical criteria for medical necessity.

ADMINISTRATIVE AND CLINICAL APPEALS

A. The following individuals may submit an appeal of an adverse determination:
    - Any member or his/her designated representative
    - Any authorized health care provider or practitioner
    - The authorized provider, practitioner, or enrollee's attorney or a legislative or regulatory agency, such as an insurance commissioner

B. The appeal may be submitted in writing to Humana, unless an oral request is allowed by the state, and must be submitted within 180 days from the date of the adverse determination to the address outlined in the adverse determination letter.

Note: Unless the member's plan or any applicable state law allows additional time to submit an appeal.

EXPEDITED APPEALS PROCESS

A. An expedited appeal is an emergency request for review of a Humana certification denial of emergency care, care for life threatening conditions, or continued stays for hospitalized patients.

B. Expedited appeals may be requested by telephone, fax, or in writing to the phone or fax numbers outlined in the adverse determination letter.

C. The party appealing may be required to provide information necessary to review the appeal. Participating providers must respond to the Grievance and Appeals (G&A) department's records request expeditiously with submission of the required medical records to comply with time frames established by the state Department of Insurance for the processing of grievances and appeals. Charges for copying medical records are considered a part of office overhead and are to be provided at no cost to members and Humana, unless state regulations stipulate differently. Information will be reviewed by a behavioral health care provider who has not previously reviewed the case and who is of the same or similar specialty as would typically manage the condition.

E. A determination will be made within 72 hours of receipt of the expedited request or as expeditiously as the enrollee's health condition requires unless the state mandates a shorter time frame.

F. The results of an expedited appeal are relayed telephonically to the practitioner/facility and the member if required by the state. Oral notification is provided within 72 hours followed by a written notification to the member, practitioner, and facility within three calendar days, unless otherwise specified by the state or health plan.

G. Notification of the appeal determination will include a statement of the specific medical or contractual reasons for the resolution, the clinical criteria used to review the appeal, and additional appeal rights if applicable.

STANDARD APPEALS PROCESS

A. Depending on state regulations, the appeal may be submitted in writing to Humana, unless an oral request is allowed by the state.

B. Humana will notify the appellant in writing within five (5) business days of receipt of the written appeal, unless the state mandates a shorter time frame.

C. Humana may request additional specific information or documentation necessary in order to review the appeal. Participating providers must respond to the G&A department's records request expeditiously with submission of the required medical records to comply with time frames established the state Department of Insurance for the processing of grievances and appeals. Charges for copying medical records are considered a part of office overhead and are to be provided at no cost to members and Humana, unless state regulations stipulate differently.

E. Results of the appeal will be given in writing to the member or authorized representative. The provider is notified when applicable and if required by the state.

Note: Some states or plans allow more (or less) time for Humana's decision.

F. Notification of the appeal determination will include a statement of the specific medical or contractual reasons for the resolution, the clinical criteria used to review the appeal, and additional appeal rights if applicable.

RIGHT TO AN INDEPENDENT APPEAL

Depending on the state requirements, if an adverse determination is upheld on appeal, the appellant may have the right to have the decision reviewed by someone completely independent of the health plan and the utilization review agent. An Independent Review Organization (IRO) or an external review may be requested.

Instructions, process, and availability of IROs vary by state and type of benefit plan. Please reference the adverse determination letter for information on obtaining an independent review.

If the IRO is available and determines that the enrollee should receive the health care services previously denied, the claim will be processed. If the IRO agrees that the health care services were not medically necessary or appropriate, the care will not be covered. The decision of the IRO is final and binding.

CLAIMS RECONSIDERATION PROCESS

For all products, if upon receipt of an initial claim determination from Humana via Explanation of Benefits or Automated Remittance Advice, the provider disagrees with the determination made by Humana and would like to request a reconsideration/reopening of the issue, providers may do so by contacting Humana in one of two ways: by telephone or via written correspondence. Members can have specific addresses or telephone numbers associated with their membership, so it is best to utilize the contact information located directly on the back of the ID card of the member in question. If the provider does not have this information, he/she may contact Humana via the following general phone number or mailing address:

Phone: 1-800-4HUMANA
Address: Humana Correspondence
P.O. Box 14601
Lexington, KY 40512

When sending a written request for reconsideration/reopening of a claim, the following information must accompany the request:

- Provider name and Tax ID
- Member name and identification number
- Date(s) of service
- Charged amount
- Payment amount
- A brief description of the basis for the contestation as well as any supporting documentation

All provider requests for claims reconsiderations must be received by Humana within 18 months of the date the claim was paid, unless state or federal law or the provider agreement require another time period, or the claim will not be reopened or reconsidered.

If the provider is unsatisfied with the determination made on the phone call, or upon receipt of the determination made by the Humana Claims Research Unit or Correspondence Team that completed the review, he/she may submit a request for a second reconsideration/reopening to humanaproviderservices@humana.com. The Humana Provider Services Team reviews escalated issues when providers are unable to obtain resolution to reconsiderations/reopenings via normal submission methods. Providers will need to include the member's information, claim information, the reference ID numbers provided on previous contacts to Humana, and any other information relevant to the review (medical records, copy of invoice, etc.). Within 48 hours of the email submission, the provider will receive a reference ID number that he/she may use to contact Customer Service to receive status of the review at any time.

Note: The above provisions of this section are to be considered as separate and distinct from the arbitration provisions set forth in the provider's agreement.

CONTRACTED PROVIDER PROCESS

Per the provider's contractual agreement with Humana, the member cannot be billed for services except for payment of any applicable copayments, deductibles, coinsurance, and services not covered by the member's health plan.

A. If the treating provider or designee does not agree with the determination and believes that the member's health, life or ability to regain maximum function may be jeopardized by the post-service appeal, the provider may request an expedited appeal by submitting a request to the Commercial Expedited G&A contact center

    Phone: 1-888-259-6767

Fax: 1-920-339-2112
This contact center is for expedited appeals only

Note: The party appealing may be required to provide information necessary to review the appeal. Participating providers must respond to the G&A department's records request expeditiously with submission of the required medical records to comply with time frames established by the state Department of Insurance for the processing of grievances and appeals. Charges for copying medical records are considered a part of office overhead and are to be provided at no cost to members and Humana, unless state regulations stipulate differently.

B. A Humana physician reviewer, who was not involved in the denial determination, will review all information submitted, and make a determination within the time frames based on the state and federal requirements.

C. Otherwise, within 180 days from receipt of this notice, a post-service appeal may be submitted only with an Authorization of Representation (AOR), unless otherwise mandated by the state or health plan. We complete post-service appeal determinations within 30 calendar days from receipt of the request, unless the state defines a different time frame.

D. You may send us written comments, documents, records, or other information regarding your appeal. We will consider all available information relevant to your appeal when we make our review.

MEDICARE APPEALS PROCESS

The Medicare appeals process is available to Medicare Advantage members and is regulated by CMS. This process is intended to resolve disputes resulting from Humana's initial determination regarding the denial or reduction of a claim to a Medicare Advantage member.

Initial determination is defined as Humana's first decision regarding a request for coverage of a service or additional benefits concerning:

- Reimbursement for emergency services (either in or out of the service area), urgently needed services outside of the service area, post-stabilization care, or out-of-area renal dialysis
- Services from a provider not under contract with the plan, which the member believes are covered under Medicare, and should have been authorized for coverage by the plan
- Refusal to authorize coverage for services, which the member believes to be covered in whole or in part, including the type or level of services
- Discontinuance of coverage for a service if a member disagrees that the service is no longer medically necessary
- Failure to provide payment for health care services in a timely manner or failure to provide the member with timely notice of an adverse coverage determination (if the delay would adversely affect the member's health)

Initial determination may be made by one of the following:

- Humana physician reviewer
- Claims department
- Delegated entities

Standard organizational determination decisions should be rendered as expeditiously as the Medicare Advantage member's health condition requires, but no later than 14 calendar days from the date the organization received the request. Requests not acted upon within 14 calendar days constitute an automatic expedited initial organizational denial and may be appealed by the Medicare beneficiary without further delay. Notification of denials for precertification of non-urgent care must be made to members in writing within two business days of the decision. Notification for concurrent review decisions that result in a denial must be issued in writing within one business day of the original notification.

If the initial determination is to deny or reduce payment of services, the plan or physician/provider must send the member written notice of the decision within 60 days. After 60 days, the denial is automatically considered to be an adverse initial determination. This written notice must:

- Contain approved language in a readable and understandable format.
- State the specific reasons for the decision. The reasons must clearly specify the grounds for denial (e.g., "We denied your request of payment for outpatient psychotherapy services you received out of plan. As stated in your membership materials, out-of-plan services are not covered when you are in the service area except in an emergency or as authorized by the plan. Our records show the services you received were not emergent and were not authorized.").
- Describe clinical criteria used to make decisions and make that information available upon request.
- Advise the member of alternative benefits when available.
- Inform the member or physician/provider of his/her right to request a reconsideration.
- Describe both the standard and expedited appeal rights, as applicable.

Failure to inform the member or provider of Humana's decision in writing within the 60-day period constitutes an adverse initial determination and may be appealed by the member or physician/provider. If the member or provider elects to appeal the adverse initial determination, he/she may request reconsideration. Directions should be given on how to request a reconsideration of the determination.

The Humana Claims Department is responsible for informing members or providers of payment denial by sending them an Explanation of Benefits (EOB) statement. The back of the EOB includes an explanation of the right to reconsider.

The entity making the initial determination is responsible for notifying the member or provider of its decision. In all cases, the issuing entity should keep a copy of the determination notice. This notice must be a CMS and Humana approved document. Contact Humana Customer Service for the current version of the notice.

Requesting a reconsideration: A member or his/her legal or appointed representative may request a reconsideration in writing, or via fax, and may either mail the request or file it in person. The

request should be made within 60 calendar days of the date of notice of the adverse initial determination. However, an exception may be granted if a party shows good cause. The request for reconsideration may be filed with Humana.

The G&A department is responsible for receiving and processing all requests for reconsideration and ensuring that all supporting documentation is obtained. A letter of acknowledgment will be sent to the member, authorized representative, or physician/provider within five (5) days of receipt of the request for reconsideration. A decision will be made by someone other than the person involved in making the initial determination.

The plan has 30 calendar days to issue its reconsidered determination for standard preservice requests and 60 days to issue a reconsideration determination and send payment for standard requests for payment. If the plan upholds the initial determination in whole or part, Humana Behavioral Health G&A must forward the case to an Independent Review Entity (IRE) for review. The IRE will inform the member or provider and the plan of its decision. If the IRE upholds the plan's decision, the member or provider will be informed of his/her right to an Administrative Law Judge (ALJ) hearing, if applicable.

Expedited initial determinations: If a member's health warrants a quicker response, an expedited initial determination may be requested for health care services. The basic requirements are the same as those for routine initial determinations, except that the time frame to render a decision is expedited and not to exceed 72 hours. Furthermore, oral requests are permitted. The plan will always grant a physician's/provider's request to expedite an initial determination.

Expedited reconsideration process: An expedited reconsideration is a verbal or written request from an MA member or an authorized representative, or a physician/provider to appeal (reconsider) a service denial, termination of care, or a reduction in the level of care when that determination, if processed according to the standard appeal time frame, could seriously jeopardize the enrollee's life, health or ability to regain maximum function, including cases in which the Plan makes a less than fully favorable decision to the member. Determinations for expedited reconsiderations are made as quickly as possible, but not to exceed 72 hours.

Immediate Quality Improvement Organization review: Medicare members who believe they are being prematurely discharged from the hospital have the right to request an immediate Quality Improvement Organization (QIO) review of the provider's decision to discharge them. The member should receive advanced notice of the discharge to allow adequate time for the Medicare member to make a decision whether to request immediate QIO review.

Humana has an established process for providers to use to notify Humana of any complaints or concerns. Providers have the option of calling Customer Service or following the grievance and appeal process. In any of these events, staff will be assigned to assist providers with their concerns. A provider handout is available on the humanabehavioralhealth.com website on the Provider page under the "Tools" section, which has important contact information.

CHAPTER 8: COVERED SERVICES

A service must be medically necessary and covered by the member's policy to be paid by the plan. The plan determines whether services are medically necessary as defined by the member's Certificate of Coverage/Evidence of Coverage. To verify covered or excluded services, call HBH Customer Service at the number listed on the back of the member's ID. All services may be subject to applicable copayments, deductibles, and coinsurance.

Please note in the absence of any state or account specific contractual criteria, the MCG Behavioral Health Care Guidelines will be applied.

HBH makes coverage determinations, including medical necessity determinations, based upon the member's Certificates of Coverage/Evidence of Coverage. However, HBH is not a provider of services and it does not control the clinical judgment or treatment recommendations made by the providers in its networks or who may otherwise be selected by members. Providers make independent health care treatment decisions.

CHAPTER 9: CLINICAL PRACTICE GUIDELINES

HBH has adopted several clinical practice guidelines (CPG) from the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) to support providers in making decisions regarding appropriate behavioral health care for specific clinical circumstances and to improve consistency, patient care and safety. These evidence-based guidelines are known to be effective in improving health outcomes. HBH has chosen the practice guidelines for treatment of patients with bipolar disorder, major depressive disorder, schizophrenia and substance use as the current focus guidelines in the adult population, as these diagnoses are among the most common for members. For adolescents and children, HBH has selected attention-deficit/hyperactivity disorder, depressive disorders and substance use practice guidelines. These guidelines may be accessed at humanabehavioralhealth.com. Paper copies are also available by request at 1-866-279-7214, option 1.

HBH assesses compliance with CPGs annually. The sample selection represents the high volume practitioners in each market where Humana has business. High volume is defined as a provider who sees 10 or more enrollees three or more times in a 12-month period. Reviews are conducted in the provider's office to allow for face-to-face contact and training. The performance goal is 85 percent. During record reviews, HBH will focus on two elements for each guideline.

Bipolar Disorder: For bipolar disorder, HBH measures performance with a) the prescription of mood-stabilizing medication and b) education of the patient or family regarding bipolar disorder. Both measures are based on specific recommendations in the guideline. The first is based on numerous recommendations in the CPG for first-line psychopharmacologic treatment. The second is based on recommendations about the importance of educating patients and appropriate family members.

Major Depressive Disorders: For major depressive disorders, HBH measures performance with a) the completion of a risk assessment and b) education of the patient or family regarding depression.

Both measures are based on specific recommendations in the guideline. The first is based on a clear recommendation that an assessment of suicide risk is crucial. The second is based on a recommendation regarding the importance of educating patients and appropriate family members.

Schizophrenia: For schizophrenia, HBH measures performance with a) the prescription of anti-psychotic medication and b) education of the patient or family regarding schizophrenia. Both measures are based on specific recommendations in the guideline. The first is based on numerous recommendations in the CPG for first-line psychopharmacologic treatment. The second is based on recommendations about the importance of educating patients and appropriate family members.

Substance Use: For substance use, HBH measures performance with a) the completion of an assessment for co-morbid disorders and b) referral to a support group such as Alcoholics Anonymous or Narcotics Anonymous. Both measures are based on specific recommendations in the guideline. The first is based on the recommendation that comorbidity should be assessed due to the high prevalence of comorbid psychiatric conditions in substance abuse patients. The second is based on a recommendation regarding the importance of self-help group support, as active participation has been correlated with better treatment outcomes.

Attention-deficit/Hyperactivity disorder: For attention-deficit/hyperactivity disorder, HBH measures performance with a) the completion of an assessment for comorbid disorders and b) referral to a support group such as Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD). Both measures are based on specific recommendations in the guideline. The first is based on the recommendation that comorbidity should be assessed due to the high prevalence of comorbid psychiatric conditions in ADHD patients. The second is based on a recommendation regarding the importance of self-help group support.

Please note: The clinical practice guidelines are not a substitute for the sound clinical judgment of the behavioral health care provider and are intended only to assist the provider in making decisions about appropriate health care for specific clinical circumstances. Clinical practice guidelines may include treatment that requires prior authorization and/or may not be covered by the member's health plan. All authorizations for care are based on medical necessity and are applied within the benefit plan structure.

CLINICAL CRITERIA

Humana Behavioral Health utilizes the MCG Behavioral Health Care Guidelines for utilization management decisions. The guidelines include consideration of characteristics for 17 different service settings and the medical necessity of the proposed treatment services. They contain criteria specific to mental health and substance-related services for adults and children/adolescents for each of the service settings, are symptom-driven and focus on the severity and degree of impairment caused by the member's presenting problems. MCG Behavioral Health Care Guidelines also contain criteria related to therapeutic and testing procedures and are applied to appropriate requests. Humana Behavioral Health also utilizes clinical criteria specified by state or federal law mandates (if applicable).

Please note that in the absence of any state or account-specific contractual criteria the MCG Behavioral Health Care Guidelines will be applied.

Criteria used for adverse determinations are disclosed to the physician, practitioner, provider, patient, and/or patient's authorized representative in the adverse determination written notification. Copies of the specific criteria used to make determinations are available upon request. To request a copy of the MCG Behavioral Health Care Guidelines, please call 1-877-264-2548.

CHAPTER 10: QUALITY/UTILIZATION MANAGEMENT

QUALITY MANAGEMENT

Upon request, Humana Behavioral Health will make available to providers a description of its quality improvement program and a summary report on Humana Behavioral Health's progress in meeting quality improvement goals. You may request a paper copy by contacting the Quality Improvement Program at 1-866-270-4223 or emailing qi@humanabehavioralhealth.com.

Quality management activities: HBH quality management activities include, but are not limited to, the following:

- Treatment records reviews – Conducted to meet requirements of accrediting agencies and federal and state law requirements. Annually, HBH may review a sample of records. HBH does not review all records and is not responsible for ensuring the adequacy or completeness of records. Please see appendix for more information.

- Clinical measurement activities – Programs designed to improve the quality of clinical care and service provided to members who demonstrate behavioral health conditions.

- Occurrences and adverse events reporting – Unexpected occurrences and adverse events involving members are reported to the quality management department by providers and/or case managers. Cases are reviewed according to HBH's quality management process as required by law and accrediting agencies.

- Member complaints – Member complaints and grievances pertaining to quality-of-care concerns may be referred to the quality management department for review.

- Preventative behavioral health programs – Humana Behavioral Health offers disease/condition-specific preventive health programs to provide the member with education and support. For more information, contact the Quality Improvement Program at 1-866-270-4223 or by email at qi@humanabehavioralhealth.com.

PREVENTIVE HEALTH PROGRAMS

Humana Behavioral Health selects preventive health programs to prevent or detect the incidence, emergence, or worsening of behavioral health disorders. HBH selects at least two relevant preventive health programs that cover the children/adolescent and adult population of its members. Humana Behavioral Health also solicits appropriate input for the prevention programs by

obtaining feedback from providers and members. Preventive health programs are based on reasonable scientific evidence and knowledge of best practices.

Current providers are notified of the preventive health programs and encouraged to actively support the program when discussing it with members. Members who have been identified quarterly through claims or authorization data will receive written notification of the preventive behavioral health programs as well as encouragement to use them. Written notification also informs the member how to call Humana Behavioral Health's toll-free number to have his/her name removed from the list.

As an HBH contracted provider, you may be afforded the opportunity to have your patients participate in a behavioral health screening. Online tools and supporting documents will indicate what tools are available as a resource for your members. Humana Behavioral Health also encourages members to use preventive behavioral health services by visiting humanabehavioralhealth.com.

UTILIZATION MANAGEMENT PROCESS

Utilization management is the process by which Humana Behavioral Health evaluates the medical necessity and appropriateness of proposed care in order to promote quality, cost-effective care for a member.

- **Levels of Care:** Humana Behavioral Health recognizes six distinct levels of care, each with specific criteria for treatment, admission, continued stay and discharge. The first level of care is self-help or social services. The remaining five levels of care are considered formal treatment and may qualify for payment by the member's plan. Those five levels of care are routine outpatient, intensive outpatient, partial hospitalization (or day hospital), residential treatment, and acute inpatient care.

- **Accessing care (precertification):** In order to access care, members or providers can call the toll-free number listed on the back of the member's insurance card. The representative will gather demographic data, determine eligibility and transfer the call to a clinical care manager. The clinical advisor will gather clinical information and make a determination regarding certification of care. If the clinical advisor determines that clinical criteria for medically necessity are met, a letter to the member and provider will be sent verifying specific services have been precertified.

- **Emergency, Urgent and Routine Care:** Humana Behavioral Health makes a distinction between emergency, urgent, and routine care. If it is determined that the member's situation is an emergency, the clinical advisor will work to schedule a session with a network provider within four (4) hours or refer the member to the nearest network facility or emergency room for immediate evaluation. If the member and the clinical care manager agree that urgent care is needed, the first appointment should be scheduled within 48 hours of the request for services. If the member is requesting more routine services, then Humana Behavioral Health network providers should be able to schedule the first session within 10 business days of the request.

Note: For Medicare members, prior authorization does not need to be obtained for emergency or urgent care, regardless of whether services are obtained within or outside the Humana provider network.

After the first visit or after a member has been admitted to a facility, it becomes the network provider's responsibility to contact Humana within 24 hours of that admission, with a proposed treatment plan, in order to certify any continued treatment. Please note: The certification letter is not a guarantee of payment; it is only verification that the services requested meet medical necessity clinical criteria. Claims payment will be determined at the time the claim is submitted.

- **Concurrent Utilization Review:** Once treatment has begun, the provider or facility will contact Humana Behavioral Health with clinical information to support the need for continued treatment. The provider may submit this information by telephone. Facility based care is conducted over the phone. At each utilization review, if there is medical necessity for the continued services requested, the clinical advisor will authorize additional days up to the limits of the member's benefit plan.

Outpatient Therapy and Medication Management

Providers may request outpatient or medication management visits either by telephone or via Onlineauth.com.

Physician Review: In some cases, the clinical adviser may need to consult with a physician reviewer when medical necessity may be unclear for either outpatient or facility-based care. Humana Behavioral Health uses a board-certified, licensed psychiatrist to review such cases. If the physician reviewer renders the opinion that the clinical information provided does not meet medical necessity criteria for continued treatment at that level of care, the clinical adviser will contact the facility or provider by telephone to arrange for a peer-to-peer reconsideration. Based on this conversation, the physician reviewer may authorize continued care or will deny further services at that level of care. If denied, Humana Behavioral Health then will send an adverse determination letter to the member, the facility and provider stating the specific reasons why services were determined not to be medically necessary. If the care is medically necessary, the clinical advisor will generate a certification notice. A copy will be sent to the provider or facility and the member. If the care is certified, the clinical advisor will schedule the next concurrent review as applicable.

DISCUSSING UTILIZATION MANAGEMENT DENIAL DECISIONS

Humana Behavioral Health provides the opportunity to discuss any utilization management denial decision based on medical necessity or clinical appropriateness with a licensed, board-certified psychiatrist or another appropriate doctoral-level behavioral health reviewer. To schedule a discussion with a reviewer, please contact the Humana Behavioral Health telephone number on the back of the member's insurance card or call the help line at 1-800-777-6330.

Appeals: In the event the physician reviewer determines that the care requested does not meet the medical necessity clinical criteria, the member, provider or authorized representative may request an appeal. Please review the Grievance and Appeal process in Chapter 7.

- **Medical Necessity Denial:** The member and the provider or facility may elect to proceed with the requested service although it may not be covered by the health insurance policy or benefit plan. The participating provider or facility must provide the member with advance written notice that: (a) identifies the proposed services, (b) informs the member that such services may be deemed by Humana and/or Payor to be not medically necessary, and (c) provides an estimate of the cost to the member for such services to which the member agrees to in writing in advance of receiving such services to assume financial responsibility for such services.

AFFIRMATIVE STATEMENT REGARDING INCENTIVES

HBH certification decisions are based only on the appropriateness of care and service, as well as the existence of coverage.

Humana Behavioral Health does not reward physician reviewers, case managers, employees, providers or other individuals for issuing denials of coverage or service.

Humana Behavioral Health does not pay incentives to physician reviewers, employees, providers or other individuals to reduce the provision of care, which is deemed medically necessary.

Humana Behavioral Health does not give financial incentives to physician reviewers, case managers, employees, providers or other individuals to encourage decisions that result in underutilization of care or services.

CONTINUITY AND COORDINATION OF CARE

Humana Behavioral Health is committed to supporting quality care by ensuring the lines of communication are open and well-coordinated between behavioral health care providers, primary care providers (PCPs), and all other treating providers. Behavioral health providers are to coordinate care with PCPs, other behavioral health providers, and facilities when treating the same member. The Coordination of Care form is included with initial certifications of care for all members. A paper copy is available by request at 1866-279-7214. Humana Behavioral Health conducts record reviews on a continual basis with network practitioners by identifying high-volume providers and evaluating random samples of treatment records for a signed release of information and for evidence that the exchange of information occurred, with the patient's PCP and/or other behavioral health providers. Evidence can be a fax transmittal receipt, letter or documentation of a conversation regarding the member's treatment.

The following are communication expectations for coordination of care:

Humana Behavioral Health expects all providers to communicate with other behavioral health practitioners and medical care professionals treating a member in order to coordinate and manage care appropriately between treatment professionals.

Coordination and communication should take place:

- Within 60 days of the initiation of treatment;
- Periodically during treatment;

- When there is a change in diagnosis or medications;
- At the time of discharge or termination of care; and
- Between all levels of care.

The coordination of care between behavioral health care providers and medical care professionals improves the quality of care to our members in several ways:

- Communication can confirm for a primary physician that his or her patient followed through on a referral to a behavioral health professional.
- Coordination minimizes potential adverse medication interactions for a patient's prescribed psychotropic medication.
- Coordination allows for better management of treatment and follow-up for patients with coexisting behavioral and medical disorders.
- Continuity of care across all levels of treatment and between behavioral and medical treatment results in proper diagnosis and treatment that maximize the health care system's resources.
- Coordination can reduce the risk of relapse in patients with substance abuse disorders.

All treating providers are expected to facilitate effective communication by following these guidelines:

- Request the patient's written consent to exchange information with all appropriate treating professionals during the diagnostic assessment session.
- Following the initial assessment, provide other treating professionals with the following information:
  - Brief summary of patient's evaluation
  - Diagnosis
  - Medications (if evaluation was by a prescriber)
  - Treatment plan summary

- Update other behavioral health providers and primary and referring physician when the patient's condition or medications change.
- At the completion of the treatment, send a copy of the termination summary to the other treating professionals.
- Attempt to obtain all relevant clinical information from treating professionals that pertains to the patient's mental health or substance abuse problems.

Humana Behavioral Health asks that providers attempt to obtain the member's consent to exchange treatment information with behavioral health providers, medical care providers (primary care physicians and specialists) and facilities. Some consumers may refuse to allow for release of this information, and this decision must be noted in the clinical record.

A sample form for the release of information, for the exchange of information and for the member's desire to decline coordination of care are available at humanabehavioralhealth.com.

CHAPTER 11: OFFICE PROCEDURES

Compliance with regulatory and industry standards is required of all HBH network providers. This compliance is an essential component in effective, quality treatment. HBH monitors compliance through an audit of member records and on-site visits. Contracted practitioners are required to participate and allow access.

TREATMENT RECORDS

Each provider office will maintain complete and accurate treatment records for all Humana members receiving behavioral health services in a format and for time periods as required by the following:

- Applicable state and federal laws
- Licensing, accreditation, and reimbursement rules and regulations to which Humana is subject
- Accepted industry practice and standards

Note: HBH has developed guidelines for treatment record documentation, standards for the availability of treatment records, and performance goals to define our expectations for providers. HBH assesses compliance with treatment record documentation standards annually. The sample selection represents 50 percent of the high-volume practitioners and providers in each market where Humana has business. High volume is defined as a provider who sees 10 or more enrollees three or more times in a 12-month period. Reviews are conducted in the provider's office to allow for face-to-face contact and training. The performance goal is 85 percent. Each practitioner, provider and group receives verbal notification of their results at the time of the on-site review with recommendations for improvement. Official results are mailed to the provider within 10-14 days of the visit. Tools are provided to assist the provider or facility in meeting the standards.

EXPECTATIONS FOR TREATMENT RECORDS

The following are HBH's expectations for treatment record-keeping practices:

- Confidentiality of treatment records is maintained according to applicable state and federal regulations. Providers must establish procedures that comply with federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information.
- Provider office staff is trained and experienced in handling confidential information. Evaluation/retraining is conducted at regular intervals.
- Access to treatment records is limited to appropriate staff members in the office setting. Records must be organized, stored in a secure area, maintained in an accurate and timely manner and retrievable to ensure availability to providers, office staff, HBH, and the courts, if subpoenaed, or as required by law/statute.
- Providers ensure that any request for records is legally permissible prior to making an associated disclosure.
- All requests for consultation and lab reports are documented. Additionally, the review of reports from such requests is documented.

- Purging of treatment records is done according to state law. For Medicare enrollees, records must be maintained for 10 years.
- A review of a provider's treatment records meets the set performance goal of 85 percent compliance with documentation standards that are measured annually.

HBH's treatment record documentation standards and review tool are located on Humana Behavioral Health's website at humanabehavioralhealth.com and also are included in the appendix of this manual. Providers may call 1-866-279-7214 to request a paper copy.

The provider's treatment records **must be available** for utilization, risk management, peer review studies, customer service inquiries, grievance and appeal processing, and other initiatives HBH may be required to conduct.

The participating provider must respond to the HBH or Payor G&A unit expeditiously with submission of the required treatment records to comply with time frames established by CMS and/or the state Department of Insurance for the processing of grievances and appeals. Only those records for the time period designated on the request should be sent. A copy of the request letter should be submitted with the copy of the record. The submission should include test results, office notes, referrals, telephone logs, and consultation reports.

To be compliant with HIPAA, providers must make reasonable efforts to restrict access and limit routine disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose of the disclosure of member information.

If a Health Maintenance Organization (HMO) plan member changes his/her PCP for any reason, the provider must transfer a copy of the member's treatment record to the member's new PCP at the request of HBH, Payor or member. The participation agreement states whether the original or a copy of the treatment record must be sent. If a provider terminates, the provider is responsible for transferring the members' treatment records.

Charges for copying treatment records are considered a part of office overhead and are to be provided at no cost to members, HBH or Payor, unless state regulations stipulate differently.

CHAPTER 12: ACCREDITATION AND REGULATORY COMPLIANCE

Accreditation and regulatory requirements vary by state and accreditation organization. Accrediting agencies generally measure plan and provider performance against accreditation standards.

Regulatory agencies: HBH is subject to regulation by numerous state and federal agencies. These agencies routinely audit HBH and its contracted providers to measure compliance with agency standards, rules, and regulations.

National Committee for Quality Assurance (NCQA): The NCQA review process examines the organization's quality improvement program structure, tests quality improvement processes, and looks for evidence that quality improvement activities have resulted in measurable improvement in

the organization's performance. HBH is routinely reviewed to maintain Managed Behavioral Health Organization (MBHO) Accreditation status.

CHAPTER 13: CMS MEDICARE ADVANTAGE GUIDELINES

HBH is responsible for including certain CMS Medicare Advantage related provisions in the policies and procedures distributed to the physicians/providers who constitute our behavioral health services delivery network. The following table summarizes these provisions, which may be accessed via the CMS website:

Summary of CMS Requirement	CFR 42 (Section)
Safeguard privacy and maintain records accurately and timely	422.118
Permanent "out-of-area" members to receive benefits in continuation area	422.54(b)
Prohibition against discrimination based on health status	422.110(a)
Pay for emergency and urgently needed services	422.100(b)
Agreements with providers to demonstrate "adequate" access	422.112(a)(1)
Services available twenty-four (24) hrs/day, seven (7) days/week	422.112(a)(7)
Adhere to CMS marketing provisions	422.80(a), (b), (c)
Ensure services are provided in a culturally competent manner	422.112(a)(8)
Maintain procedures to inform members of follow-up care or provide training in self-care as necessary	422.112(b)(5)
Document in a prominent place in medical record if individual has executed advance directive	422.128(b)(1)(ii)(E)
Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)
Continuation of benefits provisions (may be met in several ways, including contract provision)	422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)
Payment and incentive arrangements specified	422.208
Subject to applicable federal laws	422.504(h)
Disclose to CMS all information necessary to (1) Administer and evaluate the program (2) Establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services	422.64(a): 422.504(a)(4) 422.504(f)(2)

Must make good-faith effort to notify all affected members of the termination of a provider contract 30 calendar days before the termination by plan or provider. (Chapter 4 of the Medicare Managed Care Manual states that if the plan has notice at least 60 days prior to the effective date of the termination, the plan should provide members with notice more than 30 days prior to the effective date of the termination.)	422.111(e)
Submit data, medical records and certify completeness and truthfulness	422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)
Comply with medical policy, quality improvement and medical management	422.202(b); 422.504(a)(5)
Disclose to CMS quality and performance indicators for plan benefits re: disenrollment rates for beneficiaries enrolled in the plan for the previous two years	422.504(f)(2)(iv)(A)
Disclose to CMS quality and performance indicators for the benefits under the plan regarding enrollee satisfaction	422.504(f)(2)(iv)(B)
Disclose to CMS quality and performance indicators for the benefits under the plan regarding health outcomes	422.504(f)(2)(iv)(C)
Notify providers in writing for reason of denial, suspension and termination	422.202(d)(1)
Provide 60 days of notice (terminating contract without cause)	422.202(d)(4)
Comply with Federal laws and regulations to include, but not limited to: Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act)	422.504(h)(1)
Prohibition of use of excluded providers	422.752(a)(8)
Adhere to appeals/grievance procedures	422.562(a)

CHAPTER 14: HUMANA EAP AND WORK-LIFE SERVICES

This chapter outlines processes, procedures, and contact information specific to EAP services that are different from those listed in the previous chapters.

Harris, Rothenberg International, Inc., dba Humana EAP and Work-Life Services, and its subsidiary, provide a full range of Employee Assistance Program (EAP) services to client organizations, their employees, and beneficiaries.

Participation in Humana Behavioral Health's EAP and Work-Life Services network requires an executed HBH Provider Participation Agreement, along with the EAP Provisions Attachment. Specific EAP requirements for case management are outlined in the EAP Provisions Attachment.

Contact us

Member eligibility, preauthorization, notification and claims
1-888-704-7979 or the number provided by the member

Clinical services

The provider is responsible for verifying the client's benefits and eligibility and can do so by calling the EAP Provider Resource Line at 1-888-704-7979.

All EAP services provided to Humana EAP and Work-Life Services clients must be authorized by Humana EAP and Work-Life Services. EAP counseling services are not subject to medical necessity criteria or utilization management processes. The number of EAP visits depends on the member's particular contract/plan.

Claims procedures

Humana does not reimburse for EAP appointments that were canceled by the member or those where the member failed to show for an appointment. Providers agree not to charge a member for missed sessions.

EAP claims must be submitted on a Case Information Update Form (CIUF) on either the EAP Billing Form (included in the authorization notification packet) or a CMS 1500 form within 90 days of the final EAP session to ensure prompt payment and avoid claim denial. The Explanation of Payment (EOP) or Remittance Advice will be mailed separately from any payment for claims once the claim is processed.

EAP claims and claims reconsiderations should be mailed to:

Humana EAP and Work-Life Services
2101 W. John Carpenter Freeway, Suite 150
Irving, TX 75063

Or faxed to: 1-866-331-5673

Note: Online billing is not available for EAP claims.

FREQUENTLY ASKED QUESTIONS

Q. Where do I send claims?

A. Behavioral Health:
Humana Claims Office, P.O. Box 14601, Lexington, KY 40512

Employee Assistance Program:
Humana EAP and Work-Life Services
2101 W. John Carpenter Freeway, Suite 150
Irving, TX 75063

Or fax: 1-866-331-5673

Q. Can I bill a patient for differences not paid by insurance?

A. Providers who are in the preferred provider network for Humana are contracted not to bill for amounts that exceed the pre-negotiated rates. Patients are responsible only for copayments and deductibles. Providers may bill a patient for services not covered under the enrollee's benefit, but only if the patient has been notified by the provider in writing in advance.

A. For EAP sessions, as stipulated in the EAP Provisions Attachment, patients are not billed directly for any charges, including a missed session.

Q. I saw a patient but failed to get precertification. Will I get paid for the sessions(s)?

A. Most insurance plans managed by Humana require precertification for claims payment. Others will pay at reduced rates. To ensure maximum reimbursement for your services, it is recommended that all sessions be certified prior to the appointment. If precertification is not completed prior to the session, you should call as soon as possible to speak with a case manager. Of course, exceptions will be made in the case of emergencies.

Q. Do I have to call HBH for precertification of routine outpatient visits every time a patient has an appointment?

A. If preauthorization is required by the member's health plan, every service/unit needs to be authorized. Outpatient precertifications cover multiple units for an allotted date range. Once the authorization is exhausted, you will need to call and request a new authorization.

Please note that Humana may review a claim request for service to determine medical necessity at any time regardless of precertification requirements. All services must be medically necessary in order to be considered for payment. (EAP sessions are not subject to medical necessity or utilization review criteria.)

APPENDIX: QUALITY OF CARE STANDARDS

STANDARDS FOR TREATMENT RECORD DOCUMENTATION

1. Every page contains the patient's name or identification number.

2. Every patient record includes the patient's:
   - Home address
   - Employer or school
   - Home and work telephone numbers
   - Emergency contacts' telephone numbers
   - Marital or legal status
   - Appropriate consent forms (informed consent, consent to treat, medication consent, release of information, and coordination of care form)
   - Guardianship information, if relevant

3. All entries in the treatment record:
   - Are dated
   - Are in sequential order
   - Include the treating provider's name and professional degree
   - Are legible to someone other than the writer

4. Presenting problems relevant psychosocial and social conditions are routinely and prominently identified and revised.

5. Imminent risk or potential risk of harm to self or others is prominently noted, documented and revised frequently.

6. A psychiatrist or prescriber documents in each record the medications prescribed, dosages of each, dates of the initial prescription, allergies and adverse reactions to medications.

7. A medical and psychiatric history is documented, including previous treatment dates, names of previous providers and therapeutic interventions and responses.

8. Prenatal events and developmental history are documented for children and adolescents.

9. Past and present use of alcohol and illicit, prescribed and over-the-counter drugs are documented for all patients.

10. Documentation of mental status evaluation includes the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.

11. The diagnosis is documented and is consistent with the presenting problems, history, mental status examination, and/or other assessment data.

12. Treatment plans are consistent with diagnosis; have both objective and measurable goals, and estimated time frames for goal attainment or problem solving; and are signed by the patient.

13. The focus of treatment interventions is consistent with the documented treatment plan goals and objectives.

14. Progress notes describe patient strengths and limitations in achieving treatment plan goals, objectives, and symptoms relevant to the diagnosis.

15. The treatment record documents preventive services as appropriate (e.g., relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community services) and documents follow-up appointments (e.g.: RTC 2 weeks).

16. Family therapy for children and adolescents is documented and occurred within 60 days of the initial visit with a follow-up family session scheduled.

17. Adherence to the clinical practice guidelines adopted by Humana as outlined in Chapter 9.

18. Coordination of care between behavioral health providers and the primary care physician (PCP) is noted in the record. The record includes:
    - Evidence that the practitioner presented the client/patient with a release of information form to exchange information with the PCP and other behavioral health care providers.
    - Evidence that the client/patient signed a release of information form either granting or denying permission for coordination of care and exchange of information with the PCP and other behavioral health care providers.
    - Evidence that the signed and completed form was faxed and/or mailed within 60 days from the initiation of treatment. A copy of a letter or form is retained in the chart, or there is documentation in the notes that exchange of information was completed telephonically or in person.
    - Evidence that information exchanged was sufficient and included the diagnosis, treatment plan and medications (if applicable).