



# **FLORIDA MEDICAID PROVIDER MANUAL**

## Welcome

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

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

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

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

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

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## SECTION I – HUMANA MEDICAL PLAN

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### PROGRAM DESCRIPTION

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

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

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

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

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

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

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

- Health Maintenance Organizations
- Provider Service Networks
- Children’s Medical Services Network

Most Medicaid recipients must enroll in the MMA program, the following individuals are NOT required to enroll, although they may enroll if they choose to:

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

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

- Region 1: Escambia, Okaloosa, Santa Rosa and Walton counties
- Region 2: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla and Washington
- Region 3: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee and Union
- Region 4: Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia
- Region 5: Pasco and Pinellas
- Region 6: Hardee, Highlands, Hillsborough, Manatee and Polk counties
- Region 7: Brevard, Orange, Osceola and Seminole
- Region 8: Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota
- Region 9: Indian River, Martin, Okeechobee, Palm Beach and St. Lucie counties
- Region 10: Broward County
- Region 11: Miami-Dade and Monroe counties

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

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

1. Preserving continuity of care
2. Requiring sufficient and accurate networks under contract and taking patients, allowing for an informed choice of plans for recipients and the ability to make appointment.
3. Paying providers fully and promptly to preclude provider cash flow or payroll issues, and to give providers ample opportunity to learn and understand the plan’s prior authorization procedures

4. Coordinating with the Choice Counseling Call Center and website operated by the Agency's contracted enrollment broker

## DEFINITIONS

The following are definitions that are specific to this Appendix:

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

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

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

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

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

**"Exploitation" of a vulnerable adult means a person who:**

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

**Action** — The denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b). The reduction, suspension or termination of a previously authorized service. The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner, as defined by the state. The failure of the Managed Care Plan to act within

ninety (90) days from the date the Managed Care Plan receives a grievance, or forty-five (45) days from the date the Managed Care Plan receives an appeal. For a resident of a rural area with only one (1) managed care entity, the denial of an enrollee's request to exercise the right to obtain services outside the network.

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

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

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

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

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

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

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

**Agency** — State of Florida, Agency for Healthcare Administration or its designee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Children/Adolescents** — Enrollees younger than 21.

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

**Children's Medical Services Plan** — A Medicaid specialty plan for children with chronic conditions operated by the Florida Department of Health's Children's Medical Services Network as specified in s. 409.974(4), F.S., through a single, statewide contract with the agency that is not subject to the SMMC

procurement requirements, or regional plan limits, but must meet all other plan requirements for the MMA program.

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

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

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

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

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

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

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

**Complaint** — Any oral or written expression of dissatisfaction by an enrollee submitted to the Health Plan or to a state agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships, such as rudeness of a provider or Health Plan employee, failure to

respect the enrollee's rights, Health Plan administration, claims practices or provision of services that relates to the quality of care rendered by a provider pursuant to the Health Plan's Contract. A complaint is an informal component of the grievance system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Screening services must be provided in accordance with reasonable standards of medical and dental practice determined by the Agency after consultation with recognized medical and dental organizations involved in child Healthcare. Requirements for screenings are contained in the Medicaid Well-Child Visits Coverage and Limitations handbook. Diagnosis and treatment include: (a) diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids; (b) dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and (c) appropriate immunizations. (If it is determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time.) (See definition of Well-Child Visits program.)



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

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

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

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

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

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

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

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

**Enrollees with Special Healthcare Needs** — Enrollees who face physical, behavioral or environmental challenges daily that place at risk their health and ability to fully function in society. This includes individuals with mental retardation or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; children/adolescents and adults with certain environmental risk factors such as homelessness

or family problems that lead to the need for placement in foster care; and all enrollees in LTC Managed Care Plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Grievance Process** — The procedures for addressing enrollees' grievances.

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

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

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

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

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

**Healthcare Professional** — A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), a licensed clinical social worker, registered respiratory therapist and certified respiratory therapy technician.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Nonparticipating Provider** — A person or entity eligible to provide Medicaid services that does not have a contractual agreement with the Managed Care Plan to provide services. To receive payment for covered services, nonparticipating providers must be eligible for a Medicaid provider agreement and recognized in the Medicaid system (Florida MMIS) as either actively enrolled Medicaid providers or as Managed Care Plan registered providers.

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

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

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

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

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

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

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

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

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

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

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

**Physician Assistant (PA)** — A person who is a graduate of an approved program or its equivalent or meets standards approved by the Board of Medicine or the Board of Osteopathic Medicine, and is

certified to perform medical services delegated by the supervising physician in accordance with Chapter 458, F.S.

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**State** — State of Florida.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Well-child Visits** — Comprehensive and preventive health examinations provided on a periodic basis that are aimed at identifying and correcting medical conditions in children/adolescents. Policies and procedures are described in the Well-Child Visits Coverage and Limitations Handbook.

## ENROLLEE IDENTIFICATION (ID) CARD

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

**Humana.**  
**Humana Medical Plan**

**MEMBER NAME**  
**Member ID: HXXXXXXXXX**

Medicaid ID#: XXXXXXXX	Group #: XXXXXXXX
Date of Birth: XX/XX/XX	RxBIN: 610649
Effective Date: XX/XX/XX	RxPCN: 03190000

PCP Name: XXXXXXXXX  
 PCP Phone: (XXX) XXX-XXXX  
 Primary Care Address: XXXXXXXXXXXX

Member/Provider Service:	1-800-477-6931
Member Behavioral Health Inquiries:	1-888-778-4651
Pharmacist Rx Inquiries:	1-800-865-8715
Provider Prior Authorization:	1-800-523-0023

**For online provider services, go to [www.availity.com]**

Please mail all claims to:  
**Humana Medical**  
**P.O. Box 14601**  
**Lexington, KY 40512-4601**

**Humana.**  
**Humana Medical Plan**

**MEMBER NAME**  
**Id. del afiliado: HXXXXXXXXX**

Id. de Medicaid: XXXXXXXX	N.º de grupo: XXXXXXXX
Fecha de nacimiento: XX/XX/XX	RxBIN: 610649
Fecha de entrada en vigor: XX/XX/XX	RxPCN: 03190000

Nombre del PCP: XXXXXXXXX  
 No. de teléfono del PCP: (XXX) XXX-XXXX  
 Dirección de atención primaria: XXXXXXXXXXXX

Servicio para afiliados/proveedores:	1-800-477-6931
Preguntas del afiliado sobre salud de la conducta:	1-888-778-4651
Consultas sobre recetas de farmacéuticos:	1-800-865-8715
Autorización previa de proveedores:	1-800-523-0023

**Acuda a [www.availity.com] para servicios de proveedores en línea**

Por favor, envíe todas las reclamaciones por correo a:  
**Humana Medical**  
**P.O. Box 14601**  
**Lexington, KY 40512-4601**

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## COVERED SERVICES

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### GENERAL SERVICES

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

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

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

### **OUT-OF-NETWORK CARE FOR SERVICES NOT AVAILABLE**

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

### **EXPANDED SERVICES**

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

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

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

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## EMERGENCY SERVICE RESPONSIBILITIES

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

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

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

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

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

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

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

## EMERGENCY BEHAVIORAL HEALTH SERVICES

For mental health services, enrollees should call the mental Healthcare provider in their area. The provider can give the enrollee a list of common problems with behavior and talk to the enrollee about how to recognize the problems. Members may call Humana's Behavioral Health toll-free number at 1-888-778-4651.

Treatment for psychiatric and emotional disorders includes the following services:

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

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

### **Emergency mental health conditions include:**

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

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

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

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

1. Provide a health screening evaluation that should consist of comprehensive health and developmental history, including assessment of past medical history, developmental history and behavioral health status; comprehensive unclothed physical examination; developmental assessment; nutritional assessment; appropriate immunizations according to the appropriate Recommended Childhood Immunization Schedule for the United States; laboratory testing (including blood lead testing); health education (including anticipatory guidance); dental screening (including a direct referral to a dentist for enrollees beginning at 3 years of age or earlier as indicated); vision screening, including objective testing as required; hearing screening, including objective testing as required; diagnosis and treatment; and referral and follow-up as appropriate.
2. For children/adolescents who the primary care provider identifies through blood lead screenings as having abnormal levels of lead, the primary care provider should provide case management follow-up services as required in Chapter 2 of the Well-Child Visits Coverage and Limitations Handbook.



Screening for lead poisoning is a required component of health screening. Humana requires all providers to screen all enrolled children for lead poisoning at 12 and 24 months of age. In addition, children between the ages of 12 months and 72 months of age must receive a blood screening lead test if there is no record of a previous test. The primary care provider should provide additional diagnostic and treatment services determined to be medically necessary to a child diagnosed with an elevated blood lead level. The primary care provider should recommend, but not require, the use of paper filter tests as part of the lead screening requirement.

3. The primary care provider should inform enrollees of all testing/screenings due in accordance with the periodicity schedule specified in the Medicaid Well-Child Visits Coverage and Limitations Handbook. The primary care provider should contact enrollees to encourage them to obtain health assessments and preventive care.
4. The primary care provider should refer enrollees to appropriate service providers within four weeks of the examination for further assessment and treatment of conditions found during the examination.
5. The primary care provider shall cover fluoride treatment for children/adolescents even if the Health Plan does not provide dental coverage. Fluoride varnish application in a physician's office is limited to children up to 3 ½ years (42 months) of age.
6. The primary care provider should offer scheduling assistance and transportation to enrollees to assist them to keep, and travel to, medical appointments.
7. The well child program includes the maintenance of a coordinated system to follow the enrollee through the entire range of screening and treatment, as well as supplying CHCUP training to medical care providers.
8. Pursuant to s. 409.975(5), F.S., Humana shall achieve a CHCUP screening rate of at least 80 percent for those enrollees who are continuously enrolled for at least eight (8) months during the federal fiscal year (Oct 1-Sept 30). This screening compliance rate is based on the CHCUP screening data reported by the primary care provider and due to the Agency by Jan 15 following the end of each federal fiscal year. The data should be monitored by the Agency for accuracy, and, if the primary care provider does not achieve the 60 percent screening rate for the federal fiscal year reported, the primary care provider should file a corrective action plan (CAP) with the Agency no later than Feb 15, following the fiscal year reported. Any datum reported by the primary care provider found to be inaccurate should be disallowed by the Agency, and the Agency should consider such findings as being in violation of the contract and may sanction the primary care provider accordingly.
9. Humana will adopt annual screening and participation goals to achieve at least an 80 percent CHCUP screening and participation rate. For each federal fiscal year that the Humana Provider Network does not meet the 80 percent screening and participation rate, Humana must file a CAP with the Agency no later than Feb 15, following the federal fiscal year being reported.

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## WELL-CHILD VISITS

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### **PRESCRIBING PSYCHOTROPIC MEDICATION TO A CHILD**

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

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

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

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

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

### **CHILD HEALTH CHECKUP**

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

#### **What are the components of the Well-child Visits?**

A well-child visit is composed of the following:

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

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

**Please refer to the following Well-child Visits information and screening codes:**

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

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

Well-child Visits age or description	Well-child ICD-10 codes	New patient codes	Established patient codes
Neonatal exam	NA	99460, 99461, 99463	NA
Two to four days for newborns discharged less than 48 hours after delivery	NA		
By 1 month	NA	99381	99391
2 months	NA		
4 months	NA		
6 months	NA		
9 months	NA		
12 months	NA	99382	99392
15 months	NA		
18 months	NA		
2 years to 4 years	NA		
5 years to 11 years	NA	99383	99393
12 years to 17 years	NA	99384	99394
18 years to 20 years	NA	99385 EP	99395 EP
Routine well-child visit	V20.2	99202 – 99205	99213 – 99215
Routine general medical exam	V70.0		

Well-child Visits age or description	Well-child ICD-10 codes	New patient codes	Established patient codes
Other medical exam for administrative purpose	V70.3		
Health exam of defined subpopulation	V70.5		
Health exam in population survey	V70.6		
Other specified general medical exam	V70.8		
Unspecified general medical exam	V70.9		

## CHILD BLOOD LEAD SCREENINGS

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

### Importance of lead testing:

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

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

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## PROVIDER COMPLAINTS

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For all inquiries, including complaints, please contact Humana customer service at **1-800-477-6931** or email [FLMedicaidProviderRelations@humana.com](mailto:FLMedicaidProviderRelations@humana.com). Based on the type of issue or complaint, your inquiry will be reviewed by a Humana associate with the designated authority to resolve your issue or complaint.

A provider complaint may be filed using the following steps:

### VERBAL COMPLAINT

A Customer Service Specialist (CSS) will receive the initial call and attempt to resolve any issues or concerns at the time of the call. If the provider requests to file a complaint, the CSS will log the details in the database immediately, document the verbal acknowledgement given to the provider and transfer the complaint to the Provider Complaint Resolution teams which represent the following departments: Provider Call Center, Provider Relations, Claims, Correspondence, Prior Authorization Team, and Clinical Intake Call Team.

Upon receipt of a complaint involving nonclaims from the Customer Service Specialist (CSS), the Provider Complaint Resolution teams will thoroughly investigate each complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the Plan's written policies and procedures. The Provider Complaint Resolution teams will contact the provider and/or provider's office to research and resolve the issue within 90 days of receipt. Every 15 days, a written status report will be sent to the provider until the issue is resolved. A written notice of the disposition and the basis of the resolution will be sent to the provider within three business days of resolution.

### WRITTEN COMPLAINT

The provider should submit in writing to:

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

Or email to:

[FLMedicaidProviderRelations@humana.com](mailto:FLMedicaidProviderRelations@humana.com)

Upon receipt of a complaint involving nonclaims from the Humana Provider Correspondence team, the Provider Complaint Resolution teams will thoroughly investigate each complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all

parties and applying the Plan's written policies and procedures. The Provider Complaint Resolution teams will contact the provider and/or provider's office to research and resolve the issue within 90 days of receipt. Every 15 days, a written status report will be sent to the provider until the issue is resolved. A written notice of the disposition and the basis of the resolution will be sent to the provider within three business days of resolution.

For provider complaints related to claims, the provider should follow the same process outlined above. Please note the time frames for filing a claims complaint or reconsideration are listed in the table below.

## CLAIMS COMPLAINTS

Topic	Response
In what manner may the claims complaint be submitted?	In writing to: Humana Provider Correspondence P.O. Box 14601 Lexington, KY 40512-4601 Or email to: <a href="mailto:FLMedicaidProviderRelations@humana.com">FLMedicaidProviderRelations@humana.com</a> Telephone: <b>1-800-477-6931</b>
What is the time frame for Provider to submit a claims complaint/reconsideration?	Participating providers: 18 months Nonparticipating physician: 12 months Nonparticipating facility: 30 months
Is an acknowledgement of the claims complaint required?	No
What is the resolution time frame?	Within 60 days after the receipt of the provider's request for review or appeal, unless claim is under active review by a mediator, arbitrator, or third-party dispute entity.
What is the time frame for Provider to submit a claim for overpayment?	Provider shall report to Humana when it has received an overpayment within sixty (60) days after the date on which the overpayment was identified, and must notify Humana in writing of the reason for the overpayment as required by 42 CFR 438.608(d)(2), to be mailed to:  Humana Healthcare Plans P.O. Box 931655 Atlanta, GA 31193-1655

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## GRIEVANCE SYSTEM

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

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

### FILING A GRIEVANCE OR AN APPEAL

If an enrollee has questions or an issue, he or she may call Humana Customer Service at **1-800-477-6931** between 8 a.m. and 8 p.m.

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

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

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

The enrollee has the right to continue services during the grievance/appeal process. If the enrollee would like his/her services to continue, the enrollee must submit an appeal within 10 business days after the notice of action is mailed; or within 10 business days after the intended effective date of action, whichever is later. However, if the decision of the Grievance/Appeal Committee is not in the enrollee's favor, the enrollee may have to pay for those services.

#### **The grievance/appeal must have the following:**

- Name, address, telephone number and ID number
- Facts and details of what actions were taken to correct the issue
- What action would resolve the grievance/appeal
- Signature
- Date

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

#### Florida Medicaid Grievance First-Level Review

Topic	Response
In what manner may the grievance be submitted?	Oral or written
What is the time frame to submit the grievance?	Unlimited
Is an appointment of representation (AOR) required?	Yes
Is an Acknowledgment of the Grievance required?	Yes, within five business day of receipt
What is the resolution time frame?	No later than 90 calendar days of receipt

**Appeal:** An enrollee must file the appeal either verbally or in writing within 60 calendar days of the receipt of the notice of action, and except when expedited resolution is required, must be followed with a written notice within 10 calendar days of an oral filing. The date of the oral notice will be considered the date of receipt. An enrollee has up to one year to file an appeal if the denial is not in writing. Humana will resolve the appeal as quickly as the health condition requires. A letter telling the enrollee the outcome of the appeal will go out within 45 days from the date Humana receives the request. The enrollee can request a 14-day extension if needed. We also can request an extension if additional information is needed and is in the enrollee's best interest. Humana will inform the enrollee by mail of any extra time needed to make a decision, what additional information is needed and why it is in the enrollee's best interest.

#### Florida Medicaid Appeal First-Level Review

##### Determination

Topic	Response
In what manner may the appeal be submitted?	Oral (must be followed by written request within 10 calendar days from the oral filing) or written  If the request is submitted orally, the date the oral appeal is made is considered the date of receipt.
What is the time frame to submit the appeal?	Within 60 days from the date of the notice of adverse action
Is an appointment of representation (AOR) required?	Yes



Topic	Response
Is an Acknowledgment of the Appeal required?	Yes, within five business days of the appeal receipt
What is the decision notification method?	Written
What is the decision time frame?	Appeal determinations should be rendered as expeditiously as the member's health condition requires but no later than 30 calendar days from receipt, whether received orally or in writing.

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

**Humana** shall not discriminate against **Provider** or take punitive action against a **Provider** who requests an expedited resolution or supports a member's appeal, as required by 42 CFR 438.410(b).

#### Florida Medicaid Expedited Appeal First-Level Review

Topic	Response
In what manner may the appeal be submitted?	Oral or written
What is the time frame to submit the appeal?	Within 60 calendar days from the date of the notice of action
Is an appointment of representation (AOR) required?	Yes, except from the provider
Is an Acknowledgment of the Appeal required?	Yes, oral acknowledgment is required no later than 24 hours of receipt
What is the decision time frame?	As expeditiously as the member's health condition requires but not to exceed 72 hours after receipt, whether the request was submitted orally or in writing

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

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

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

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

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

[https://portal.flmmis.com/FLPublic/Provider\\_ContactUs/tabId/38/Default.aspx](https://portal.flmmis.com/FLPublic/Provider_ContactUs/tabId/38/Default.aspx)

They are as follows:

Agency for Healthcare Administration  
Medicaid Hearing Unit  
P.O. Box 60127  
Fort Myers, FL 33906

Call toll free: 1-877-254-1055

Fax: 1-239-338-2642

Email: [MedicaidHearingUnit@ahca.myflorida.com](mailto:MedicaidHearingUnit@ahca.myflorida.com)

[Appeal\\_Hearings@dcf.state.fl.us](mailto:Appeal_Hearings@dcf.state.fl.us)

Web: [www.myflfamilies.com/about-us/office-inspector-general/investigation-reports/appeal-hearings](http://www.myflfamilies.com/about-us/office-inspector-general/investigation-reports/appeal-hearings)

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

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

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

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

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

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

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

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

Office hours are from 9 a.m. to 5 p.m. Eastern time, Monday through Friday

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

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

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

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## CHRONIC AND COMPLEX CONDITIONS

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### COMPREHENSIVE DIABETES CARE

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

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

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

### NEPHROPATHY

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

### CONGESTIVE HEART FAILURE

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

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

## **ASTHMA**

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

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

## **HYPERTENSION**

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

## **HIV/AIDS**

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

## **TUBERCULOSIS**

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

1. Said enrollees shall be hospitalized and treated in a hospital licensed under Chapter 395 F.S. and under contract with the FDOH pursuant to 392.62, Florida Statutes;
2. Treatment plans and discharge determinations shall be made solely by FDOH and the treating hospital;
3. For enrollees determined to be a threat to public health and receiving tuberculosis treatment at an

FDOH contracted hospital, the Managed Care Plan shall pay the Medicaid per diem rate for hospitalization and treatment as negotiated between Florida Medicaid and FDOH, and shall pay any wrap-around costs not included in the per diem rate; and

4. Reimbursement shall not be denied for failure to prior authorize admission, or for services rendered pursuant to 392.62 F.S.

## **TELEPHONIC MEDICAID DISEASE MANAGEMENT PROGRAM**

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

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

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

- Asthma
- Cancer
- Diabetes
- Congestive heart failure
- Hypertension
- HIV+/AIDS
- Mental Health
- Adult/Pediatric asthma
- Substance Abuse

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

- Evaluating member needs that can affect control of their disease such as physical limitations, mental health effects, transportation difficulties and environmental needs
- Developing self-management goals and plan of care considering members' health history, psychosocial assessment, providers' plan of care and members' needs
- Educating on diagnosis and potential treatment modalities
- Referring to internal and external programs
- Supporting members and providers regarding diagnosis, plan of care and other health-related concerns
- Educating and assisting members on reaching disease-specific diet and exercise goals
- Educating members on recommended health checks

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

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

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

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

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

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

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

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

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

If you have questions or concerns related to utilization management, staff is available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday by calling **1-800-393-8858**.

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



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## PCP AND OTHER PROVIDER/SUBCONTRACTOR RESPONSIBILITIES

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### ACCESS TO CARE

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

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

The PCP provides, or arranges for, coverage of services, consultation or approval for referrals 24 hours per day, seven days per week (24/7) by Medicaid-enrolled providers who will accept Medicaid reimbursement. This coverage shall consist of an answering service, call forwarding, provider call coverage or other customary means approved by the Agency. The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach the PCP for a clinical decision. The after-hours coverage must be accessible using the medical office's daytime telephone number. The PCP arranges for coverage of primary care services during absences due to vacation, illness or other situations that require the PCP to be unable to provide services. A Medicaid-eligible PCP must provide coverage.

### AMERICANS WITH DISABILITIES ACT (ADA)

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

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

If you have members who need interpretation services, they can call the number on the back of their member ID cards or visit Humana's website at: [www.humana.com/accessibility-resources](http://www.humana.com/accessibility-resources).

## TRANSITION/COORDINATION OF CARE OF NEW ENROLLEES

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

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

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

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

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

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

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

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

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

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

- Put the enrollee with a new case manager
- Identify members who desire to transition/continuity of care
- Determine unmet needs and put necessary services in place
- Coordinate and build relationships with providers

## **FAMILY PLANNING SERVICES**

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

### **Family Planning Services and Supplies**

- The Managed Care Plan shall provide family planning services to help enrollees make comprehensive and informed decisions about family size and/or spacing of births. The Managed Care Plan shall provide the following services: planning and referral, education and counseling, initial examination, diagnostic procedures and routine laboratory studies, contraceptive drugs and supplies, and follow-up care in accordance with the Medicaid Practitioner Services Coverage and Limitations Handbook.
- This information should be documented in the patient's medical record to meet the contractual requirement. Humana or AHCA may audit your medical records to confirm compliance with this contractual clause.
- Members can choose from any Medicaid doctor for family planning services. Prior approval is not needed.

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

## **IMMUNIZATIONS**

As part of Humana's focus on preventive health, we want all infants and children to receive recommended immunizations and screenings. Additionally, as detailed under section 1905(r)(1)(B)(iii) of the Social Security Act, we want to remind you of your participation in the Vaccines for Children (VFC) program and the benefits of the VFC program.

The VFC program provides vaccines at no charge to physicians and eliminates the need to refer children to county health departments for immunizations. Humana is enrolled as a data partner with Florida SHOTSPTMP. Additional information regarding ordering VFC program vaccines is available on the Florida SHOTSPTMP website at <http://flshotsusers.com>

**Important notes:**

- Healthcare providers can verify their participation in the VFC program at the following link: <http://www.floridahealth.gov/programs-and-services/immunization/vaccines-for-children/active-vfc-providers.html>
- Also, it's important for providers to maintain an adequate vaccine inventory. The below link provides useful information for this process: [http://flshotsusers.com/sites/default/files/inline-files/Return%20and%20Waste%20January%202016\\_508.pdf](http://flshotsusers.com/sites/default/files/inline-files/Return%20and%20Waste%20January%202016_508.pdf)
- Humana may reimburse the cost of the vaccine and an administration fee for Medicaid-eligible recipients 0 to 18 years of age who receive vaccines not available through the VFC program.
- Guidelines on how you should bill for the vaccination administration and vaccines can be found at: [http://ahca.myflorida.com/medicaid/review/Reimbursement/2017\\_10\\_01\\_Immunization\\_fee\\_schedule.pdf](http://ahca.myflorida.com/medicaid/review/Reimbursement/2017_10_01_Immunization_fee_schedule.pdf)
- Providers must cooperate with all requests for immunization records for enrollees from any local or federal agency, including the Florida Department of Children and Families (DCF).

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

**ADULT HEALTH SCREENING****Adult Preventive Health Exam – Beginning at age 21****Elements:**

1. Risk Screening
2. Interval History
3. Immunizations

**Guidelines:**

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

Interval histories are required with preventive Healthcare.

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

Immunizations are to be documented and current.

If immunization status is not current, this is to be documented with a catch-up plan. Immunizations are required as follows: influenza, annually beginning at age 65 years, Td booster every 10 years; pneumococcal vaccine beginning at age 65. When an individual has received a pneumococcal

- vaccination prior to the age of 65 years and it has been five years since the vaccination, the individual should be revaccinated.
4. Height and Weight Documented height and weight is required for all preventive Healthcare visits and at least:
    - every five years for ages 21-40
    - every two years beginning at age 41
  5. Vital Signs Pulse and blood pressure are required for all preventive Healthcare visits and at least:
    - every five years for ages 21-40
    - every two years beginning at age 41
  6. Physical Exam Appropriate evaluation for inclusion in the baseline physical examination of an asymptomatic adult are:
    - general appearance
    - skin
    - gums/dental/oral
    - eyes/ears/nose/throat
    - neck/thyroid
    - chest/lungs
    - cardiovascular
    - breasts
    - abdomen/GI
    - genital/urinary
    - musculoskeletal
    - neurological
    - lymphatic

If noncompliance or refusal is documented, the risk associated with the noncompliance must be documented.
  7. Cholesterol Screening Screening required every five years for:
    - Men, beginning age 35
    - Women, beginning age 45

(Earlier if there is any risk factor evident for cardiovascular disease)
  8. Visual Acuity Testing Visual acuity testing, at a minimum, is to document the patient's ability to see at 20 feet. Referrals for testing must be documented.

9. Hearing Screening	Test or inquire about hearing periodically/once a year.
10. Electrocardiogram	Periodically after age 40 to 50 (or as primary care deems medically appropriate).
11. Colorectal Cancer	<p>Colorectal cancer screening must be documented Screening beginning at age 50.</p> <p><b>Risk Factors:</b> First-degree relatives or personal history of colorectal cancer, personal history of female genital or breast cancer, familial adenomatous polyposis, Gardner syndrome, hereditary nonpolyposis colon cancer, chronic inflammatory bowel disease.</p>
12. Pap Smear	Baseline pap smears are required annually for three consecutive years until three consecutive normal exams are obtained; then every two to three years. May stop at age 65 if patient had regularly normal smears up to that age.
13. Mammography	<p>Required as appropriate between ages 35 and 40:</p> <ul style="list-style-type: none"> <li>– Every one to two years for women age 40 or older</li> <li>– Earlier and/or more frequent for women at high risk</li> </ul>
14. Prostate Exam/Screening	<p>U.S. Preventive Services Task Force, December 2002:</p> <p>Evidence is insufficient to recommend for or against routine screening for prostate cancer using PSA testing or digital rectal examination. The USPSTF found evidence that PSA can detect early-stage prostate cancer but mixed and inconclusive evidence that would suggest early detection improves health outcomes. There was insufficient evidence to determine whether the benefits outweigh the harms (of biopsies, complications and anxiety), especially in a cancer that may have never affected the patient's health.</p>

American College of Physicians 2004:

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

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

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

16. Osteoporosis

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

## HYSTERECTOMIES, STERILIZATIONS AND ABORTIONS

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

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

## HEALTHY START SERVICES

Providers treating enrollees who are pregnant should offer Florida's HealthyStart prenatal risk screening to each pregnant enrollee as part of her first prenatal visit. Providers conducting such screening must use the Department of Health (DOH) prenatal risk form (DH Form 3134), which can be obtained from the local county health department (CHD). One copy of the completed screening form should be kept in the enrollee's medical record, and another copy should be provided to the enrollee. Within 10 business days of completion, the provider must submit the screening form to the CHD in the county in which the prenatal screen was completed. Providers shall ensure that they document the member's preterm delivery risk assessment within the enrollee's medical record by no later than week 28.

Participating Hospitals and Birthing Centers also should complete the Florida HealthyStart Infant Postnatal Risk Screening Instrument (DH Form 3135) with the Certificate of Live Birth and transmit both documents to the CHD in the county in which the infant was born within five business days of completion. Copies of Form 3135 should be maintained by the provider, included in the enrollee's medical record and furnished to the enrollee. Humana contacts participating hospitals and birthing facilities to determine if they participate in the Department of Health electronic birth registration system. If Humana determines that the hospital or birthing facility did not file the required birth information within the required time frame, the hospital and birthing facility is educated regarding the proper process and associated timeliness standards. Humana preforms an annual audit on these requirements with the hospital and birthing center for compliance and implements a Corrective Action Plan as needed.

If the provider determines that the enrollee's pregnancy is high risk, the provider shall ensure that the obstetrical care during labor and delivery includes preparation by all attendants for symptomatic evaluation and that the enrollee progresses through the final stages of labor and immediate postpartum care.

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

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

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

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

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



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

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

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

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

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

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

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

1. The participating provider should report the following information about the mother: name, date of birth, race, ethnicity, address, contacts, laboratory test performed, date the sample was collected, the due date or estimated date of conception (EDC), and whether or not the enrollee received prenatal care and immunization dates for infants and contacts.
2. The participating provider should use the perinatal hepatitis B Case and Contact Report (DH Form 2136) for reporting purposes.

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

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

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

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

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

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

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

- Childbirth, breastfeeding and car seat education classes;
- Comprehensive assessment of service needs in light of family and community resources;
- Home visits to provide education and support for breastfeeding, baby weight checks, parenting, immunization information and safe sleep;
- Ongoing coordination to assure access to needed services and support to help families attain their goals; and
- Developmental screening, psychosocial assessments, nutritional education, smoking cessation counseling or referrals as needed.

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

Providers are required to immediately notify Humana of an enrollee's pregnancy by calling **1-800-322-2758**, whether identified through medical history, examination, testing, claims or otherwise.

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

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

## NEWBORN CARE

The Managed Care Plan shall make certain that its providers supply the highest level of care for the newborn, beginning immediately after birth. Such level of care shall include, but not be limited to, the following:

- Instilling of prophylactic eye medications into each eye of the newborn;
- When the mother is Rh negative, securing a cord blood sample for type Rh determination and direct Coombs test;
- Weighing and measuring of the newborn;

- Inspecting the newborn for abnormalities and/or complications;
- Administering one-half (0.5) milligram of vitamin K;
- APGAR scoring;
- Any other necessary and immediate need for referral in consultation from a specialty physician, such as the HealthyStart (postnatal) infant screen; and
- Newborn screening services in accordance with s. 383.14, F.S., which outlines the required laboratory screening process to test for metabolic, hereditary and congenital disorders known to result in significant impairment of health or intellect. These required laboratory tests shall be processed through the State Public Health Laboratory. The Managed Care Plan shall reimburse for these screenings at the established Medicaid rate and must enter into a provider agreement or a contract with the State Public Health Department.

## **DOMESTIC VIOLENCE, ALCOHOL AND SUBSTANCE ABUSE AND SMOKING CESSATION**

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

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

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

PCPs should screen and educate enrollees regarding smoking cessation by:

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

## **QUALITY ENHANCEMENTS**

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

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

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

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

1. **Children's Programs** — Humana and its providers are required to provide regular general wellness programs targeted specifically toward members from birth to age 5, or make a good faith effort to involve enrollees in existing community children's programs.
  - a. Children's programs should promote increased use of prevention and early intervention services for at-risk members. Humana will approve claims for services recommended by the early intervention program when they are covered services and medically necessary.
  - b. Humana is required to offer annual training to providers who promote proper nutrition, breast-feeding, immunizations, CHCUP, wellness, prevention and early intervention services.
2. **Domestic Violence** — Providers must screen members for signs of domestic violence and offer referral services to applicable domestic violence prevention community agencies.
3. **Pregnancy Prevention** — Humana and its providers are required to conduct regularly scheduled pregnancy prevention programs or make a good faith effort to involve members in existing community pregnancy prevention programs, such as the Abstinence Education program. The programs should be targeted toward teen members, but should be open to all members, regardless of age, gender, pregnancy status or parental consent.
4. **Prenatal/Postpartum Pregnancy Programs** — Humana is required to provide regular home visits conducted by a home health nurse or aide, counseling and educational materials, to pregnant and postpartum enrollees who are not in compliance with the Health Plan's prenatal and postpartum programs.
5. **Smoking Cessation** — Humana and its providers are required to conduct regularly scheduled smoking cessation programs as an option for all members or make a good faith effort to involve members in existing community smoking cessation programs. Smoking cessation counseling must be available to all members. Providers should use the Quick Reference Guide to assist in identifying tobacco users and supporting and delivering effective smoking cessation interventions. Copies of the guide may be obtained by contacting:  
  
 DHHS, Agency for Healthcare Research & Quality (AHR) Publications Clearinghouse  
 P.O. Box 8547  
 Silver Spring, MD 20907-8547  
 1-800-358-9295
6. **Substance Abuse** — Humana is required to offer substance abuse screening training to providers. Humana and its providers are required to offer targeted members either community- or plan-sponsored substance abuse programs.

## QUALITY IMPROVEMENT REQUIREMENTS

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

**Performance improvement projects (PIPs)** — Ongoing measurements and interventions, significant improvement to the quality of care and service delivery, sustained over time, in both clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

**Medical record audits** — Medical record reviews to evaluate patterns of complaints regarding poor quality of service, poor quality outcomes, and adherence to enrollee record documentation standards.

**Performance measures** — Data collected on patient outcomes as defined by the Healthcare Effectiveness Data and Information Set (HEDIS®) or otherwise defined by the Agency.

**Surveys** — Consumer Assessment of Health Plans Surveys (CAHPS®)

**Peer review** — Reviews of provider's practice methods and patterns and appropriateness of care.

### Standards for enrollee records:

1. Include the enrollee's identifying information, including name, enrollee identification number, date of birth, gender, and legal guardianship (if any);
2. Include information relating to the enrollee's use of tobacco, alcohol, and drugs/substances;
3. Include summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow up;
4. Reflect the primary language spoken by the enrollee and any translation needs of the enrollee;
5. Identify enrollees needing communication assistance in the delivery of Healthcare services;
6. Include copies of any completed consent or attestation form(s) used by the Managed Care Plan or the court order for prescribed psychotherapeutic medication for a child under the age of 13 years;
7. All enrollee records shall contain documentation that the enrollee was provided with written information concerning the enrollee's rights regarding advance directives (written instructions for living will or power of attorney), including information on Chapter 765, F.S., and whether the enrollee has executed an advance directive. (42 CFR 438.3(j)(3))
8. Neither the Managed Care Plan, nor any of its providers shall, as a condition of treatment, require the enrollee to execute or waive an advance directive. (42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5))

## COMMUNITY OUTREACH AND PROVIDER-BASED MARKETING ACTIVITIES

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

1. Healthcare providers may display health-plan-specific materials in their own offices. Providers are permitted to make available and/or distribute Humana marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all Managed Care Plans with which the provider participates. If a provider agrees to make available and/or distribute Humana's marketing materials, it should do so knowing it must accept future requests from other

Managed Care Plans with which it participates. Providers also are permitted to display posters or other materials in common areas such as the provider's waiting room. Additionally, long-term care facilities are permitted to provide materials in admission packets announcing all Managed Care Plan contractual relationships.

2. Healthcare providers cannot orally or in writing compare benefits or provider networks among health plans, other than to confirm whether they participate in a health plan's network. If a provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.
3. Healthcare providers may announce a new affiliation with a health plan through general advertising (e.g., radio, television, websites). Providers may give their patients a list of health plans with which they contract.
4. Healthcare providers may co-sponsor events, such as health fairs and advertise with the health plan in indirect ways, such as television, radio, posters, fliers and print advertisements.
5. Healthcare providers shall not furnish lists of their Medicaid patients to the health plan with which they contract, or any other entity, nor can providers furnish other health plans' membership lists to the health plan; nor can providers assist with health plan enrollment.
6. For the health plan, Healthcare providers may distribute information about non-health-plan specific Healthcare services and the provision of health, welfare and social services by the State of Florida or local communities as long as inquiries from prospective enrollees are referred to the member services section of the health plan or the Agency's choice counselor/enrollment broker. Providers may refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office. They may also share with patients information from the Agency's website or CMS's website.

**Providers may not:**

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

## FLORIDA MEDICAID PROVIDER NUMBER

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

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

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

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

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

## PROVIDER CONTRACTS, CREDENTIALING AND RECREDENTIALING

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

- Visit [Humana.com/providers](https://www.humana.com/providers).
- Choose "Join Our Network."



- Choose “Contracting with Humana.”
- Complete online form.

They may also contact their local Provider Contract office.

The following information will be needed for the contracting process:

- Physician/practice/facility name
- Service address with phone, fax and email information
- Mailing address, if different than service address
- Taxpayer identification number (TIN)
- Specialty
- Medicaid provider number
- National Provider Identifier (NPI)
- CAQH® number
- Lines of business (e.g., Medicaid, Medicare, etc.) of interest
- Type of contract (e.g., individual, group, facility)

Healthcare providers must be credentialed prior to network participation to treat Humana members.

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

- Humana participates with CAQH® (Council for Affordable Quality Healthcare), a nonprofit alliance of leading health plans, networks and trade associations. A catalyst for positive change, CAQH members collectively develop and implement administrative solutions that produce meaningful, concrete benefits — for physicians, allied health professionals, their staffs, patients and plans.
- **Humana requires use of CAQH ProView® for gathering credentialing information for all network providers.**

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

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

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

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

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

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

[Medicaid Attestation for Primary Care Physicians](#)

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

[http://ahca.myflorida.com/MCHQ/Central\\_Services/Background\\_Screening/](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/).

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

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

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

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

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

**Home Health Services and Electronic Visit Verification (EVV) Systems**

In compliance with the 21<sup>st</sup> Century CURES Act, providers are required to utilize Electronic Visit Verification (EVV) to electronically monitor, track, and confirm services provided in the home setting.

**ADVANCED REGISTERED NURSE AND PHYSICIAN ASSISTANT SERVICES**

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

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

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

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

## PHARMACY

### Medicaid Preferred Drug List

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

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

You may also obtain forms and information at [Humana.com/pa](https://www.humana.com/pa).

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

- [Humana.com/medpa](https://www.humana.com/medpa)
- 1-866-461-7273 (8 a.m. – 6 p.m. Eastern time, Monday – Friday)

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

### Pharmacy Network

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

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

Humana has an over-the-counter (OTC) program through PrescribeIT (1-800-526-1490). The benefit gives each household up to a \$17.50 maximum benefit coverage amount per member per month for over-the-counter items. Orders will be shipped to the enrollee's home by UPS Inc. or the U.S. Postal

Service. There is no charge for shipping. Please allow 10 to 14 working days from when the order is received.

### Counterfeit-proof Pads

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

## HEALTHY BEHAVIORS PROGRAM

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

- **Baby Well Visit** — Member enrolls by calling 1-800-611-1467 and completing three well-baby visits before 18 months of age. They'll receive a \$10 gift card per visit, up to three after the provider claim is validated by Humana (up to three rewards totaling \$30).
- **Pediatric Well Visit** — Member enrolls annually by calling 1-800-611-1467 and completing a well-child visit. They'll receive a \$20 gift card after the provider claim is validated by Humana (up to one reward of \$20 per year).
- **Humana Family Fit** — Members 18 years and older can be self-, plan- or provider-referred by calling Humana Wellness Solutions at **1-855-330-8053**. Once enrolled in the six-month program, Humana will offer the member the following optional intervention tools:
  - Monthly newsletters with articles and activities to help them stay motivated
  - Nutritional counseling to help them with their diet

Once the member completes an initial well visit with their PCP at enrollment, they will be rewarded with a weight scale (one per lifetime). At the end of the program (180 days), if they complete another well visit with their PCP, Humana will reward them with a \$30 gift card. (\$30 is the maximum reward, per enrolled member, per lifetime.)

- **Mom's First Prenatal and Postpartum** — Members can be self-, plan- or provider-referred by calling **1-800-322-2758, ext. 1500290** and completing all prenatal and postpartum visits with their provider; they'll receive a \$30 gift card (up to one reward of \$30 per pregnancy).
- **Smoking Cessation** — Members 18 years and older can be self-, plan- or provider-referred by calling Beacon Health Options at 1-800-221-5487. Once enrolled in the six-month program, members are eligible for a \$15 gift card for completing 90 days in the program and another \$15 gift card for completing 180 days. Or if the member completes the program using a drug prescribed by their PCP to help them stop smoking, Humana will reward them with a \$20 gift card at 90 days and another \$20 gift card at program completion (180 days). The maximum reward, per enrolled member, per year is \$40.)
- **Substance Abuse** — Members 18 years and older can be self-, plan- or provider-referred by calling Beacon Health Options at **1-888-778-4651**. Members will receive a \$10 gift card for enrolling in the

six-month program. Then at 90 days of sobriety, they receive a \$20 gift card. At 180 days of sobriety, they'll receive another \$20 gift card and will complete the program (up to three rewards totaling \$50).

You can find Healthy Behavior materials here: [humana.com/provider/support/clinical/medicaid-materials/florida](https://humana.com/provider/support/clinical/medicaid-materials/florida).

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

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

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

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

Incentives and rewards cannot be used for gambling, alcohol, tobacco or drugs (except for over-the-counter drugs). All programs, including incentives and rewards, are made available to all enrollees who meet the requirements of each program. Incentives and rewards are not used to direct you to select a certain provider. The maximum reward dollar amount on incentives and rewards does not include money spent on transportation, child care provided during delivery of services or healthy behavior program services.

Incentives and rewards may take 90 to 180 days or greater to be received. Incentives and rewards are nontransferable to other Managed Care Plans or other programs. Members will lose access to earned incentives and rewards if they voluntarily disenroll from the Humana Medical Plan or lose Medicaid eligibility for more than 180 days.

### Healthy Behaviors Overview

Healthy Behaviors Program	Administered by	Duration	How to Enroll
Smoking Cessation Program*	Beacon Health Options Encompass Program	Six months	Self-, provider- or plan-referred by calling 1-800-221-5487
Substance Abuse Program*			
Humana Fit Program	Humana and Physician well visits	Six months and two physician visits	Self-, provider- or plan-referred by calling 1-855-330-8053
Mom's First Prenatal and Postpartum Program	Humana and Physician visits	All prenatal visits and one postpartum visit	Self-, provider- or plan-referred by calling 1-800-322-2758, ext. 1500290

Healthy Behaviors Program	Administered by	Duration	How to Enroll
Baby Well Visits Program	Humana and Physician well visits	Three physician visits	Member enrolls by calling 1-800-611-1467
Pediatric Well Visit Program	Humana and Physician well visits	One physician visit	Member enrolls by calling 1-800-611-1467

*\*For Region 1 and 2 members, all behavioral health services are administered through Access Behavioral Health (ABH). Only these two Healthy Behavior programs are administered through Beacon Health Options. As noted above, your office or the member may call Beacon Health Options directly to enroll.*

#### Program Claims Codes

Program	Age group	CPT codes	ICD-10-CM diagnosis codes	HCPCS codes
Baby Well Visits Program	0–18 months	<b>Well visit:</b> 99381–99385, 99391–99395, 99461	<b>Well visit:</b> Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0–Z02.9	<b>HCPCS:</b> G0438, G0439
Pediatric Well Visit Program	2–21 years	<b>Well visit:</b> 99381–99385, 99391–99395, 99461	<b>Well visit:</b> Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0–Z02.9	<b>HCPCS:</b> G0438, G0439

*Information is current as of Aug. 20, 2018. Program descriptions and rules are subject to change. Please contact your Provider Relations Representative with questions.*

#### EMERGENCY AND NONEMERGENCY TRANSPORTATION

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

#### INPATIENT HOSPITAL SERVICES

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

##### Physical and Behavioral Health

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

**Transplant Services**

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

**MINORITY RECRUITMENT AND RETENTION PLAN**

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

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

**Native Americans**

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

**SERVICE-LEVEL AGREEMENTS**

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

**Network Adequacy**

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

**Electronic Health Records (EHRs)**

Use requirements: Depending on region, 45 percent to 60 percent of Healthcare providers are:

- Using EHR in a meaningful manner
- Using a certified electronic health exchange to improve quality of Healthcare

- Using certified EHR to submit clinical quality and other Department of Health and Human Services (DHHS) prescribed measures

## ASSISTIVE CARE SERVICES

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

Required Covered Services under MMA:

- |  |  |
|--|--|
| • Advanced registered nurse practitioner     | • Hospital services                                    |
| • Ambulatory surgical center services        | • Immunizations  |
| • Assistive care services                    | • Laboratory and imaging services                      |
| • Behavioral health services                 | • Medical supplies, equipment, prostheses and orthoses |
| • Birth center and licensed midwife services | • Optometric and vision services                       |
| • Clinic services                            | • Physician assistant services                         |
| • Chiropractic services                      | • Physician services                                   |
| • Dental services                            | • Podiatric services                                   |
| • Emergency behavioral health services       | • Prescribed drug services                             |
| • Emergency services                         | • Renal dialysis services                              |
| • Family planning services and supplies      | • Therapy services                                     |
| • Healthy Start services and nursing care    | • Transportation services                              |
| • Hearing services                           | • Well-child visits                                    |
| • Home health services and nursing care      |  |
| • Hospice services                           |  |

Additional benefits covered under MMA:

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



## TELEMEDICINE

This rule applies to any person or entity prescribing or reviewing a request for Florida Medicaid services and to all providers of Florida Medicaid services that are enrolled in or registered with the Florida Medicaid program.

**Definition of Telemedicine** – The practice of Healthcare delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis or treatment.

Practitioners licensed within their scope of practice to perform the service.

Florida Medicaid reimburses for telemedicine services using interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time, interactive communication between a recipient and a practitioner.

Florida Medicaid does not reimburse for:

- Telephone conversations, chart review(s), electronic mail messages, or facsimile transmissions.
- Equipment required to provide telemedicine services.

Florida Medicaid reimburses the practitioner who is providing the evaluation, diagnosis, or treatment recommendation located at a site other than where the recipient is located.

Providers must include modifier GT on the CMS-1500 claim form, incorporated by reference in Rule 59G-4.001, F.A.C.

Physicians who will be offering and/or facilitating telemedicine services in their practices need to be aware of the following state guidelines to ensure they are informed of their responsibilities, requirements and criteria for telemedicine. Offering these services may include a review of the practice by Humana's legal designee to ensure all considerations for the practice of telemedicine have been met.

If the provider is approved by Humana to provide services through telemedicine, the protocols below must be adhered to in order to prevent fraud and abuse. Provider must implement telemedicine fraud and abuse protocols that address:

- Authentication and authorization of users;
- Authentication of the origin of the information;
- The prevention of unauthorized access to the system or information;
- System security, including the integrity of information that is collected, program integrity and system integrity; and
- Maintenance of documentation about system and information usage

Physicians offering these services to patients with Medicaid coverage need to address the following requirements:

- Telecommunication equipment and telemedicine operations meet the technical safeguards required by 45 CFR 164.312, where applicable.

- Administration of telemedicine services comply with the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal laws pertaining to patient privacy.
- Telemedicine services provided are documented in the enrollee's medical/case record.
- Telemedicine services are offered to the enrollee as a choice of whether to access services through face-to-face or telemedicine encounter. This needs to be documented in the enrollee's medical/case records.
- Telemedicine services must be performed by licensed practitioners within the scope of their practice.
- Telemedicine services must involve the use of interactive telecommunications equipment, which includes, at a minimum, audio and video equipment permitting two-way, real-time, interactive communication between the enrollee and the practitioner.

*Note: Medicaid does not reimburse for the costs or fees of any of the equipment necessary to provide services through telemedicine, including telecommunication equipment and services.*

*Physicians are encouraged to contact their provider relations representative if they are offering, or plan to offer, these services to patients with Humana Medicaid coverage.*

## **DELEGATION OR SUBCONTRACT FUNCTIONS**

In the event that Humana has authorized Provider or Subcontractor to delegate or subcontract any function of the AHCA Contract, the subcontract or delegation shall include all stated requirements of the AHCA Contract, including but not limited to information submission if applicable for management covered services as follows: (a) draft subcontract; (b) test PNV file as proof of provider network adequacy; (c) copy of applicable licensure; (d) enrollee materials; (e) population covered by the subcontractor (f) provider materials (g) model Provider agreement per Section VIII, Provider Services; and (h) approximate number of impacted enrollees. The information shall be submitted to AHCA for approval 90 days before the proposed effective date of the contract or change.

In the event that a subcontract does not comply with requirements of the AHCA contract, Humana shall promptly revise the subcontract to bring it into compliance. Humana may revoke delegation or impose other sanctions if Provider's or Subcontractor's performance under this agreement is inadequate and/or found to be out of compliance.

## **Reporting Requirements**

Physician agrees to prepare and submit all reports and clinical information required by Humana, as required by his/her Humana agreement, including Well-child Visits Program reporting if applicable, and in compliance with state and federal requirements.

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## FLORIDA HEALTH EXCHANGE INFORMATION (HIE)

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The Office of Health Information Exchange and Policy Analysis produces statutorily mandated reports, administers the Medicaid Electronic Health Record (EHR) Incentive Program, provides governance of the Florida Health Information Exchange (Florida HIE) and provides research as well as analytic support to the Agency for Healthcare Administration (AHCA).

- The Florida Health Information Network website, [www.fhin.net](http://www.fhin.net), provides information and resources relating to AHCA's initiatives for Health Information Technology (HIT) and Health Information Exchange (HIE).
- Details about services, as well as the latest news and events relating to the Florida HIE initiative and information on becoming a participant, can be found at: [www.florida-hie.net](http://www.florida-hie.net).
- Information about the Medicaid Electronic Health Record Incentive Program can be found at <http://ahca.myflorida.com>. Search "Electronic Health Record (EHR)".

Reports produced by this office can be found on the research studies and reports page at [www.floridahealthfinder.gov/researchers/studies-reports.aspx](http://www.floridahealthfinder.gov/researchers/studies-reports.aspx).

### EARLY NOTIFICATION SYSTEM (HIE ENS)

Florida's AHCA has collaborated with hospitals throughout Florida to provide real-time notifications of all admits, discharges and transfers (ADTs). The system relies on member panels submitted by health plans. Humana will work with physicians for PCP notification and member outreach, which would include:

- Physicians will receive a daily report of their patients' previous-day ER encounters.
- Humana will continue to reach out to high-utilizing members to close gaps and engage in case management.
- Physicians are encouraged to focus on reaching out and closing gaps with low-utilizing patients.

Humana recommends that physicians continue the following effective strategy of notification and education to patients:

- Immediate outreach to the patient and facilitation of PCP follow-up within three days of an ER visit;
- Education regarding the right place of treatment;
- Identification and addressing of barriers to care to foster PCP/patient relationship; and
- Referrals to other internal programs (e.g., case management and social work).

Humana recommends that physicians continue the following effective strategy of notification and education to PCPs:

- Immediate notification of patient's ER visit, including chief complaint;
- PCP follow-up appointment scheduled within three days of member's ER visit

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## PRAUTHORIZATION AND REFERRAL PROCEDURES

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

Humana will update the lists periodically and notify providers of revisions in accordance with the time frame specified in the provider agreement. In addition to [Humana.com](https://www.humana.com), preauthorization or notification requirements for a service may be obtained by contacting Humana Customer Service.

### **How to obtain a referral or an authorization:**

Participating providers can obtain referrals and/or authorizations through a variety of channels through Humana's portals — [Humana.com](https://www.humana.com) or [Availity.com](https://www.availity.com) — or by calling Humana clinical intake at 1-800-523-0023.

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

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

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

In addition, Humana shall review and make a determination on all requests for authorization of any medically necessary service to enrollees younger than 21 when the service is not listed in the service-specific Florida Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule, or is not a covered service of the plan; or the amount,

frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

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## MEDICAL RECORDS REQUIREMENTS

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

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

- Include copies of Pre-Admission Screening and Resident Review (PASRR) screening and evaluations completed in accordance with the Rule 59G-1.040, F.A.C for enrollees admitted to or residing in a nursing facility under any provision of this contract;
- For obstetrical patients, the provider shall ensure that they document the member's preterm delivery risk assessment within the enrollee's medical record by no later than week 28;
- Documentation of emergency care encounters in enrollee medical/case records with appropriate medically indicated follow-up.

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

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

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

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

## **CONFIDENTIALITY OF MEDICAL RECORDS**

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

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

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

Humana and physician agree to maintain the confidentiality of information contained in the records of the physician regarding Healthcare services rendered to members as required by state or federal law, rule or regulation, including without limitation 42 CFR, Part 431, Subpart F, 42 CFR § 438.224, and HIPAA privacy and security requirements in 45 CFR Parts 160 and 164.

## **RIGHT TO REVIEW RECORDS**

Authorized state and federal agencies, and their authorized representatives, may audit or examine provider records. This examination includes all records these agencies find necessary to determine



whether Florida Medicaid payment amounts were, or are, due. This requirement applies to the provider's records and records for which the provider is the custodian. Providers must give authorized state and federal agencies, and their authorized representatives, access to all Florida Medicaid recipient records and any other information that cannot be separated from Florida Medicaid-related records.

Providers must send, at their expense, legible copies of all Florida Medicaid-related information to the authorized state and federal agencies or their authorized representatives upon their request.

All records must be provided regardless of the media format on which the original records are retained by the provider at the time of the request. All medical records may be reproduced electronically or onto paper copies as authorized by the requestor.

**Provider** shall maintain complete and accurate fiscal, medical, social and other administrative records for medical services rendered to Medicaid Managed Care Plan Members and as are necessary to document the quality, appropriateness and timeliness of services performed under this Agreement and in compliance with applicable state and federal laws, rules and regulations and the AHCA contract. Such records shall specifically include pertinent books, financial records, medical/case records, and records of financial transactions. **Provider** agrees to maintain and retain said records for a period of 10 years after **Humana's** contract with AHCA is terminated and/or if the records are under review or audit.

**Subcontractor** agrees that the right to audit exists through 10 years from the final date of the AHCA Contract period, or from the completion date of any audit, whichever is later.

In addition to record retention requirements for practitioner or provider licensure, require that subcontractors are required to retain, as applicable, the following information in accordance with 42 CFR 438.3.(u): enrollee grievance and appeal records (42 CFR 438.416); base data (42 CFR 438.5(c); MLR reports (42 CFR 438.8(k)); and data, information, and documentation (42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608, and 42 CFR 438.610), for a period not less than 10 years from the close of the contract and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by the Managed Care Plan if the subcontract is continuous (42 CFR 438.3(h).

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## CLAIMS AND ENCOUNTER SUBMISSION PROTOCOLS AND STANDARDS

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Paper claims should be submitted to the address listed on the back of the member's ID card or to the appropriate address listed below:

**Medical Claims:**

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

**Encounters:**

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

**Behavioral Health Claims:**

Regions 1 and 2

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

**Behavioral Health Claims:**

Regions 3, 4, 5, 6, 7, 8, 9, 10, and 11

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

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

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

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

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

If there is a factual disagreement with a response, send an email with the reference number to [FLMedicaidProviderRelations@humana.com](mailto:FLMedicaidProviderRelations@humana.com).

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

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

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

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

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

AHCA requires 100 percent encounter submissions:

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

Encounters and claims identify members who have received services:

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

Sanctions for noncompliance can include liquidated damages and enrollment freezes.

Payments due as a result of covered services rendered to Medicaid members shall be made by Humana on or before 90 calendar days, or such lesser time as may be contracted for between the parties, after all properly documented invoices and/or claims, and any documentation necessary for Humana to process such claims, have been received by Humana and in accordance with the reimbursement terms and conditions of the agreement and payment rates identified in Exhibit A, which is attached hereto and incorporated by reference.

Claims payments by Humana to physicians shall be accompanied by an itemized accounting of the individual claims in the payment including, but not limited to, the member's name, the date of service, the procedure code, service units, the amount of reimbursement and identification of Humana entity.

Humana shall make no payment, directly or indirectly, to a physician as an inducement to reduce or limit medically necessary services to a member. If Humana operates a physician incentive plan, it shall not provide incentives, monetary or otherwise, for the withholding of medically necessary care.

Humana shall assume full responsibility for collections in the event of third-party liability.

## COMMON SUBMISSION ERRORS AND HOW TO AVOID THEM

Common rejection or denial reasons:

1. Patient not found
2. Insured subscriber not found
3. Patient birthdate on the claim does not match that found in our database
4. Missing or wrong information
  - a. Providers submitting with incorrect NPI/ZIP code/taxonomy
  - b. Missing NPI/ZIP code/taxonomy
  - c. Providers submitting encounters with zero-dollar value
5. Invalid HCPCS code submitted
6. No authorization or referral found

How to avoid these errors:

1. Confirm that patient information received and submitted is accurate and correct.
2. Ensure that all required claim form fields are complete and accurate.
3. Obtain proper authorizations and/or referrals for services rendered.
4. Confirm provider information (information registered with AHCA).
5. Ensure billed amounts are not zero dollar. Must submit billed charges.

## SUBMISSION OF CLEAN CLAIMS

A clean claim is one that does not contain a defect, or requires the carrier to investigate or develop prior to adjudication, and can be processed without obtaining additional information from the provider. The provider submits a clean claim by providing the required data elements on the standard claims forms along with any attachments and additional information. Claims for inpatient and facility claims are to be submitted on the UB-04 and individual professional claims are to be submitted on the CMS-1500. Clean claims must be filed within the specified contractual time frame.

### Clean Claim Examples

Per the Centers for Medicare & Medicaid Services guidance, examples of clean claims as provided in Chapter 1 – General Billing Requirements of the Medicare Claims Processing Manual are as follows:

- Not require external development (i.e., are investigated within the claims, medical review, or payment office without the need to contact the provider, the beneficiary, or other outside source) (Note: these claims are not included in CPE scoring).
- Claims not approved for payment by Common Working File (CWF) within seven days of the FI's original claim submittal for reasons beyond the carrier's, FI's or provider's control (e.g., CWF system/communication difficulties);
- CWF out-of-service-area (OSA) claims. These are claims where the beneficiary is not on the CWF host and CWF has to locate and identify where the beneficiary record resides;
- Claims subject to medical review but complete medical evidence is attached by the provider or forwarded simultaneously with EMC records in accordance with the carrier's or FI's instructions;

- Are developed on a post-payment basis; and,
- Have all basic information necessary to adjudicate the claim, and all required supporting documentation.

### Clean Claim Submission

The Centers for Medicare & Medicaid Services (CMS) developed claim forms that record the information needed to process and generate provider reimbursement. The required elements of a clean claim must be complete, legible, and accurate.

The Humana Companion Guide outlines all the information for the fields that Humana requires providers to submit a clean claim. The guide can be found at:

<http://apps.humana.com/marketing/documents.asp?file=1828697>

### CMS-1500 FORM REQUIREMENTS

Field Number	Title	Description
1	Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other	Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked.
1a	Insured's ID Number	Enter the insured's ID number as shown on insured's ID card for the payer to which the claim is being submitted. For Medicare crossover claims, enter the Medicare Identification number in this item.
2	Patient's Name	Enter the patient's full last name, first name, and middle initial as it appears on the Medicaid Identification Card or other proof of eligibility. (Required)
3	Patient's Birth Date, Sex	Enter the patient's eight-digit birth date (MM   DD   YYYY). Enter an X in the correct box to indicate gender of the patient.
4	Insured's Name	Enter the insured's full last name, first name, and middle initial. No entry required unless the recipient is covered by other insurance.
5	Patient's Address (multiple fields)	Enter the patient's address. The first line is for the street address; the second line, the city and state; the third line, the ZIP code. No entry is required, but the information may be helpful to identify a recipient if the Medicaid ID number is incorrect.
6	Patient Relationship to Insured	Enter an X in the correct box to indicate the patient's relationship to insured when Item No. 4 is completed. No entry required.
7	Insured's Address (multiple fields)	Enter the insured's address. If Item No. 4 is completed, then this field should be completed. The first line is for the street address; the second line, the city and state; the third line, the ZIP code. No entry required unless the recipient is

Field Number	Title	Description
		covered by other insurance.
8	Reserved for NUCC Use	This field was previously used to report "Patient Status." "Patient Status" does not exist in 5010A1, so this field has been eliminated.
9	Other Insured's Name	If Item No. 11d is marked, complete fields 9, 9a, and 9d; otherwise, leave blank. When additional group health coverage exists, enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item No. 2.
9a	Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
9b	Reserved for NUCC Use	This field was previously used to report "Other Insured's Date of Birth, Sex." "Other Insured's Date of Birth, Sex" does not exist in 5010A1, so this field has been eliminated.
9c	Reserved for NUCC Use	This field was previously used to report "Employer's Name or School Name." "Employer's Name or School Name" does not exist in 5010A1, so this field has been eliminated.
10a	Is Patient's Condition Related To:	When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item No. 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. Enter an X in any part(s) that apply and give corresponding information in Item 10a-c.
10b	Is Patient's Condition Related To:	When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item No. 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. Enter an X in any part(s) that apply and give corresponding information in Item 10a-c.
10c	Is Patient's Condition Related To:	When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item Number 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. Enter an X in any part(s) that apply and give corresponding information in Item 10a-c.
10d	Claim Codes	When required by payers to provide the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this field. No entry is required for Medicaid only billing. For Medicare crossover claims, enter the recipient's 10-digit Medicaid ID number.
11	Insured's Policy, Group, or FECA Number	Enter the insured's policy or group number as it appears on the insured's Healthcare identification card. If Item Number 4 is completed, then this field should be completed.
11a	Insured's Date of Birth, Sex	Enter the 8-digit date of birth (MM   DD   YYYY) of the insured

Field Number	Title	Description
		and an X to indicate the sex (gender) of the insured. No entry required.
11b	Other Claim ID (Designated by NUCC)	Enter the "Other Claim ID." No entry required.
11c	Insurance Plan Name or Program Name	Enter the name of the insurance plan or program of the insured. Some payers require an identification number of the primary insurer rather than the name in this field. No entry required.
11d	Is there another Health Benefit Plan?	When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d. Only one box can be marked. No entry required.
12	Patient's or Authorized Person's Signature	Enter "Signature on File," "SOF," or legal signature. When legal signature, enter date signed in 6-digit (MM DD YY) or 8-digit format (MM DD YYYY) format. If there is no signature on file, leave blank or enter "No Signature on File." No entry required.
13	Insured's or Authorized Person's Signature	Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File." No entry required.
14	Date of Current Illness, Injury, or Pregnancy (LMP)	Enter the 6-digit (MM DD YY) or 8-digit (MM DD YYYY) date of the first date of the present illness, injury, or pregnancy. No entry required.
15	Other Date	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM DD YY) or 8-digit (MM DD YYYY) format. No entry required.
16	Dates Patient Unable to Work in Current Occupation	If the patient is employed and is unable to work in current occupation, a 6-digit (MM DD YY) or 8-digit (MM DD YYYY) date must be shown for the "from-to" dates that the patient is unable to work. No entry required.
17	Name of Referring Provider or Other Source	Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply (ies) on the claim. Leave blank if the procedure for which you are billing was not referred, did not require approval by a MediPass primary care provider, or did not require service authorization.
17a	Other ID#	The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.
17b	NPI #	Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b. Enter either qualifier code 1D and the Medicaid provider number in 17a or the NPI number in 17b. If you enter the NPI in 17b and the referring provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida

Field Number	Title	Description
		Medicaid claims processing system, in item 17a, enter qualifier code ZZ in the small field and enter the referring physician's taxonomy in the large field of 17a.
18	Hospitalization Dates Related to Current Services	Enter the inpatient 6-digit (MM   DD   YY) or 8-digit (MM   DD   YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization. No entry is required, but an entry is preferred.
19	Additional Claim Information (Designated by NUCC)	Please refer to the most current instructions from the public or private payer regarding the use of this field. No entry required.
20	Outside Lab? \$Charges	Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim. No entry required.
21	Diagnosis or Nature of Illness or Injury	Enter the applicable ICD indicator to identify which version of ICD codes is being reported.
22	Resubmission and/or Original Reference Number	List the original reference number for resubmitted claims. No entry required.
23	Prior Authorization Number	Enter any of the following: prior authorization number, referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service.
24a	Date(s) of Service [lines 1–6]	Enter date(s) of service, both the "From" and "To" dates.
24b	Place of Service [lines 1–6]	In 24b, enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed.
24c	EMG [lines 1–6]	Check with payer to determine if this information (emergency indicator) is necessary. If the service was an emergency, enter a Y for yes in the unshaded area of the field. If the service was not an emergency, leave the item blank.
24d	Procedures, Services, or Supplies [lines 1–6]	Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service.
24e	Diagnosis Pointer [lines 1–6]	In 24e, enter the diagnosis code reference letter (pointer) as shown in Item No. 21 to relate the date of service and the procedures performed to the primary diagnosis.
24f	\$Charges [lines 1–6]	Enter the charge amount for each listed service.
24g	Days or Units [lines 1–6]	Enter the number of days or units.
24h	EPSDT/Family Plan [lines 1–	For reporting of Early & Periodic Screening, Diagnosis, and



Field Number	Title	Description
	6]	Treatment (EPSDT) and Family Planning services, refer to specific payer instructions. Hospice: For all recipients in hospice, enter H in the shaded area of Item 24h.
25	Federal Tax ID Number	Enter the "Federal Tax ID Number" (employer ID number or SSN) of the Billing Provider identified in Item No. 33. No entry required.
26	Patient's Account No.	Enter the patient's account number assigned by the provider of service's or supplier's accounting system. The provider may enter a recipient account number so that it will appear on the remittance advice.
27	Accept Assignment?	Enter an X in the correct box. Only one box can be marked no entry required.
28	Total Charge	Enter total charges for the services (i.e., total of all charges in 24f).
29	Amount Paid	Enter total amount the patient and/or other payers paid on the covered services only.
30	Reserved for NUCC Use	This field was previously used to report "Balance Due." "Balance Due" does not exist in 5010A1, so this field has been eliminated no entry required.
31	Signature of Physician or Supplier Including Degrees or Credentials	"Signature of Physician or Supplier Including Degrees or Credential" does not exist in 5010A1.
32	Service Facility Location Information	Enter the name, address, city, state, and ZIP code of the location where the services were rendered.
32a	Service Facility Location Information	Enter the name, address, city, state, and ZIP code of the location where the services were rendered no entry required.
32b	Other ID#	Enter the qualifier identifying the non-NPI number followed by the ID number no entry required.
33	Billing Provider Info & Ph #	Enter the provider's or supplier's billing name, address, ZIP code, and phone number.
33a	Billing Provider Info & Ph #	Enter the provider's or supplier's billing name, address, ZIP code, and phone number.
33b	Other ID#	Enter the qualifier identifying the non-NPI number followed by the ID number.

**UB-04 FORM INSTRUCTIONS**

<b>Form Locator</b>	<b>Title</b>	<b>Action</b>
1	Provider Name, Address, Telephone Number, Fax Number, and Country Code	Line 1: Provider Name Line 2: Street Address or Post Office Box Line 3: City, State, and Zip Code plus 4 Line 4: Telephone; Fax; Country Code (if other than USA)
2	Pay-To Name, Address, and ID	Report only when pay-to name and address is different than the Billing Provider in Form Locator 1.
3a	Patient Control Number	Enter patient's unique (alphanumeric) number assigned by the provider. Any letter or number combination up to 20 digits is acceptable.
3b	Medical Record Number	Enter the number assigned to the patient's medical or health record by the provider. This is an optional item.
4	Type of Bill	Enter the appropriate four-digit code for the type of bill from the coding table below.
5	Federal Tax Number	Upper Line: Optional federal tax sub-ID number. Lower Line: Enter as NN-NNNNNNN
6	Statement Covers Period – From Through	Inpatient: Enter the beginning and ending service dates for this bill in month, day, and year format: MMDDYY. For admission and discharge on the same day, the From and Through dates are the same. Inpatient Psychiatric Services: Enter the beginning and ending service dates of the period included by this bill in MMDDYY format. Outpatient: Enter the date of service in MMDDYY format. Only the services received in a single day can be billed on an outpatient claim, with the exception of outpatient Medicare crossover claims. The from and through dates are the same. Freestanding Dialysis Center: Enter the beginning and ending service dates in MMDDYY format for this bill. Do not show dates before the recipient's Medicaid eligibility began. For services received on a single day, the from and through dates must be the same. Hospice: Enter the beginning and ending service dates in MMDDYY format for this bill. Do not show dates before the recipient's Medicaid eligibility began. For services received on a single day, the from and through dates must be the same. Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the beginning and ending service dates for the month being billed in month, day, year format: MMDDYY.
7	Unlabeled	No entry required.
8a	Patient ID	Report only if number is different from the insured's ID in Form Locator 60.
8b	Patient Name	Enter the recipient's last name, first name, and middle initial

Form Locator	Title	Action																																																				
		exactly as it appears on the Medicaid identification card or other Medicaid proof of eligibility.																																																				
9	Patient Address	Subfield a: Street Address or Post Office Box Subfield b: City Subfield c: State Subfield d: ZIP Code Subfield e: Country Code (no entry required)																																																				
10	Patient Birthdate	Enter the patient’s date of birth in the MMDDYYYY format.																																																				
11	Patient Sex	Enter the letter “M” if the patient is male, “F” if the patient is female, or “U” if unknown.																																																				
12	Admission Date	Inpatient: Enter the patient’s date of admission in the MMDDYY format. Example: 042107 for April 21, 2007. Outpatient: Enter the date of service. Freestanding Dialysis Centers: No entry required. Hospice: Enter the patient’s date of admission in MMDDYY format. This date must be the same as the effective date of hospice election or change of election. Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the patient’s date of admission to the facility or to a new Level of Care in MMDDYY format.																																																				
13	Admission Hour	Inpatient: Not required, but desirable. Enter the code for the hour of admission converted to 24-hour time as shown below: <table><tr><th>CODE</th><th>TIME AM</th><th>CODE</th><th>TIME PM</th></tr><tr><td>00</td><td>12:00-12:59 (Midnight)</td><td>12</td><td>12:00-12:59 (Noon)</td></tr><tr><td>01</td><td>01:00-01:59</td><td>13</td><td>01:00-01:59</td></tr><tr><td>02</td><td>02:00-02:59</td><td>14</td><td>02:00-02:59</td></tr><tr><td>03</td><td>03:00-03:59</td><td>15</td><td>03:00-03:59</td></tr><tr><td>04</td><td>04:00-04:59</td><td>16</td><td>04:00-04:59</td></tr><tr><td>05</td><td>05:00-05:59</td><td>17</td><td>05:00-05:59</td></tr><tr><td>06</td><td>06:00-06:59</td><td>18</td><td>06:00-06:59</td></tr><tr><td>07</td><td>07:00-07:59</td><td>19</td><td>07:00-07:59</td></tr><tr><td>08</td><td>08:00-08:59</td><td>20</td><td>08:00-08:59</td></tr><tr><td>09</td><td>09:00-09:59</td><td>21</td><td>09:00-09:59</td></tr><tr><td>10</td><td>10:00-10:59</td><td>22</td><td>10:00-10:59</td></tr><tr><td>11</td><td>11:00-11:59</td><td>23</td><td>11:00-11:59</td></tr></table> Outpatient: No entry required, but desirable. Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry required.	CODE	TIME AM	CODE	TIME PM	00	12:00-12:59 (Midnight)	12	12:00-12:59 (Noon)	01	01:00-01:59	13	01:00-01:59	02	02:00-02:59	14	02:00-02:59	03	03:00-03:59	15	03:00-03:59	04	04:00-04:59	16	04:00-04:59	05	05:00-05:59	17	05:00-05:59	06	06:00-06:59	18	06:00-06:59	07	07:00-07:59	19	07:00-07:59	08	08:00-08:59	20	08:00-08:59	09	09:00-09:59	21	09:00-09:59	10	10:00-10:59	22	10:00-10:59	11	11:00-11:59	23	11:00-11:59
CODE	TIME AM	CODE	TIME PM																																																			
00	12:00-12:59 (Midnight)	12	12:00-12:59 (Noon)																																																			
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10	10:00-10:59	22	10:00-10:59																																																			
11	11:00-11:59	23	11:00-11:59																																																			
14	Type of Admission or Visit	Inpatient: Enter the code indicating the priority of this admission: 1. Emergency: The patient requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient is																																																				

Form Locator	Title	Action
		<p>admitted through the emergency room.</p> <p>2. Urgent: The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.</p> <p>3. Elective: The patient's condition permits adequate time to schedule the availability of a suitable accommodation.</p> <p>4. Newborn: A baby born within this facility. Use of this code necessitates the use of special Source of Admission codes. See Form Locator 15.</p> <p>5. Trauma Center: Visit to a trauma center or hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involves a trauma activation.</p> <p>9. Information not available.</p> <p>Outpatient: Enter code 1 for emergencies; code 2 for urgent cases; or code 5 (Trauma Center) if the patient was seen in a trauma center or hospital. Otherwise, no entry is required. MediPass authorization is not required if the type of admission is 1 or 5.</p> <p>Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry required.</p>
15	Source of Referral for Admission or Visit	Inpatient, Hospice, and Freestanding Dialysis Centers: Enter the code indicating the source of the referral for this admission or visit. Newborn coding must be used when the Type of Admission Code in Form Locator 14 is 4. See next page for newborn codes.
16	Discharge Hour	<p>Inpatient: Enter the hour of discharge from the hospital, converted to 24-hour time as shown in the coding table for Form Locator 13.</p> <p>Outpatient: No entry required, but desirable.</p> <p>Freestanding Dialysis Centers: No entry required.</p> <p>Hospice: No entry required.</p> <p>Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry required.</p>
17	Patient Discharge Status	Inpatient, Outpatient and Hospice: Enter the code indicating patient status as of the discharge date or last date billed in the case of interim billing as reported in Form Locator 6—Statement Covers Period.
18	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition

Form Locator	Title	Action
		Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
19	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
20	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
21	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
22	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
23	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
24	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
25	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers,

Form Locator	Title	Action
		Hospice, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
26	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
27	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
28	Condition Codes	Inpatient, Outpatient, Freestanding Dialysis Centers, Hospice, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Identify any condition relating to this bill in numeric or alphanumeric sequence. If none of the condition codes apply, leave blank. If all of the Condition Code fields are filled, use Form Locator 81 Code-Code field with qualifier code A1.
29	Accident State	When medical services resulted from an auto accident, enter the state code for the state in which the accident occurred, i.e., FL, GA, etc.
30	Unlabeled	No entry required.
31	Occurrence Code and Date	Inpatient and Outpatient: Enter the code and associated date defining a significant event relating to this bill. If only one code and date are used, they must be entered in Form Locator 31a. If more than one code and date are used, they must be entered in Form Locators 31a through 34a, then 31b through 34b, in alphanumeric sequence. Enter the date in MMDDYY format. If all of the Occurrence Code fields are filled, use available occurrence span code fields (35-36).
32	Occurrence Code and Date	Inpatient and Outpatient: Enter the code and associated date defining a significant event relating to this bill. If only one code and date are used, they must be entered in Form Locator 31a. If more than one code and date are used, they must be entered in Form Locators 31a through 34a, then 31b through 34b, in alphanumeric sequence. Enter the date

Form Locator	Title	Action
		in MMDDYY format. If all of the Occurrence Code fields are filled, use available occurrence span code fields (35-36).
33	Occurrence Code and Date	Inpatient and Outpatient: Enter the code and associated date defining a significant event relating to this bill. If only one code and date are used, they must be entered in Form Locator 31a. If more than one code and date are used, they must be entered in Form Locators 31a through 34a, then 31b through 34b, in alphanumeric sequence. Enter the date in MMDDYY format. If all of the Occurrence Code fields are filled, use available occurrence span code fields (35-36).
34	Occurrence Code and Date	Inpatient and Outpatient: Enter the code and associated date defining a significant event relating to this bill. If only one code and date are used, they must be entered in Form Locator 31a. If more than one code and date are used, they must be entered in Form Locators 31a through 34a, then 31b through 34b, in alphanumeric sequence. Enter the date in MMDDYY format. If all of the Occurrence Code fields are filled, use available occurrence span code fields (35-36).
35	Occurrence Span Code and Dates	If Condition Code C3 was entered in Form Locators 18-28, enter the Occurrence Code M0 and the first and last days that were approved when not all of the stay was approved.
35a	Occurrence Span Code and Dates	If Condition Code C3 was entered in Form Locators 18-28, enter the Occurrence Code M0 and the first and last days that were approved when not all of the stay was approved.
36	Occurrence Span Code and Dates	If Condition Code C3 was entered in Form Locators 18-28, enter the Occurrence Code M0 and the first and last days that were approved when not all of the stay was approved.
37	Unlabeled	No entry required.
38	Responsible Party Name and Address	No entry required.
39a-d	Value Codes and Amounts	Inpatient and Outpatient: Required for Medicare and Medicaid crossovers only if one or more of the codes below is applicable. Hospice: Enter the value code and amount if applicable. 31 Patient Responsibility: If the hospice patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days. Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the value code and amount. 31 Patient Responsibility: If the patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer

Form Locator	Title	Action
		<p>system will do a prorated calculation for partial days. Medicaid reimburses the date of admission, but not the date of discharge, so that day is not included in the total number of days. If the recipient is admitted and discharged on the same day, the system will count it as one day. The Department of Children and Families (DCF) staff calculates the patient responsibility and notifies the nursing facility in writing of the correct amount of patient responsibility. The facility must receive this notice before it submits its first claim for payment. When DCF notifies a facility of a change in the amount of patient responsibility for a past month, the facility must submit an adjusted claim.</p> <p>For Medicare crossover claims (level of care X), enter the patient responsibility amount unless the recipient is a QMB only or a QMB+. There is no patient responsibility for QMB and QMB+ nursing facility residents during the Medicare coinsurance period.</p> <p>80 Covered Days: The number of days covered by the primary payer as qualified by the payer.</p>
40a-d	Value Codes and Amounts	<p>Inpatient and Outpatient: Required for Medicare and Medicaid crossovers only if one or more of the codes below is applicable.</p> <p>Hospice: Enter the value code and amount if applicable.</p> <p>31 Patient Responsibility: If the hospice patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days.</p> <p>Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the value code and amount.</p> <p>31 Patient Responsibility: If the patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days.</p> <p>Medicaid reimburses the date of admission, but not the date of discharge, so that day is not included in the total number of days. If the recipient is admitted and discharged on the same day, the system will count it as one day. The Department of Children and Families (DCF) staff calculates the patient responsibility and notifies the nursing facility in writing of the correct amount of patient responsibility. The facility must receive this notice before it submits its first claim for payment. When DCF notifies a facility of a change in the amount of patient responsibility for a past month, the facility must submit an adjusted claim.</p>



Form Locator	Title	Action
		<p>For Medicare crossover claims (level of care X), enter the patient responsibility amount unless the recipient is a QMB only or a QMB+. There is no patient responsibility for QMB and QMB+ nursing facility residents during the Medicare coinsurance period.</p> <p>80 Covered Days: The number of days covered by the primary payer as qualified by the payer.</p>
41a-d	Value Codes and Amounts	<p>Inpatient and Outpatient: Required for Medicare and Medicaid crossovers only if one or more of the codes below is applicable.</p> <p>Hospice: Enter the value code and amount if applicable.</p> <p>31 Patient Responsibility: If the hospice patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days.</p> <p>Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the value code and amount.</p> <p>31 Patient Responsibility: If the patient has a patient responsibility, enter value code 31 and the amount. The amount entered should be the amount for the entire month even when billing a partial month. The Medicaid computer system will do a prorated calculation for partial days.</p> <p>Medicaid reimburses the date of admission, but not the date of discharge, so that day is not included in the total number of days. If the recipient is admitted and discharged on the same day, the system will count it as one day. The Department of Children and Families (DCF) staff calculates the patient responsibility and notifies the nursing facility in writing of the correct amount of patient responsibility. The facility must receive this notice before it submits its first claim for payment. When DCF notifies a facility of a change in the amount of patient responsibility for a past month, the facility must submit an adjusted claim.</p> <p>For Medicare crossover claims (level of care X), enter the patient responsibility amount unless the recipient is a QMB only or a QMB+. There is no patient responsibility for QMB and QMB+ nursing facility residents during the Medicare coinsurance period.</p> <p>80 Covered Days: The number of days covered by the primary payer as qualified by the payer.</p>
42	Revenue Code	<p>Enter the appropriate four-digit revenue codes itemizing accommodations, services, and items furnished to the patient in your facility.</p> <p>Freestanding Dialysis Centers: Revenue center codes 0821 and 0831 represent covered services. Revenue Codes 0821</p>

Form Locator	Title	Action
		<p>and 0831 may be billed only once on the claim. Enter the number of units in Form Locator 46. Chapter 3 of the Florida Medicaid Freestanding Dialysis Center Services Coverage and Limitations Handbook lists the drugs that are billed with revenue center codes 0634, 0635, and 0636. When billing for a drug, enter the corresponding five-digit HCPCS procedure code in Form Locator 44. Use revenue code 0636 when dispensing AHCA-specified charges for drugs and biologics that are billed under revenue code 0636 (with the exception of radiopharmaceuticals, which are reported under Revenue Codes 0343 and 0344) require specific identification. If using a HCPCS to describe the drug, enter the corresponding five-digit HCPCS procedure code in Form Locator 44. Enter the specific service units reported in hundreds (100s); rounded to the nearest hundred; do not use a decimal.</p> <p>Note: The Florida Medicaid Freestanding Dialysis Center Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web Portal at <a href="http://mymedicaidflorida.com">http://mymedicaidflorida.com</a>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in 59G-4.105, F.A.C. Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the appropriate revenue code:</p> <ul style="list-style-type: none"> <li>• 0101 – Long Term Care days</li> <li>• 0185 – Hospital leave days (Bed-hold days)</li> <li>• 0182 – Home leave days (Therapeutic bed-hold days)</li> </ul>
43	Revenue Code Description	<p>Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter a written description of the related revenue categories included on this bill. Line 23: Page ____ of ____ - On multiple page claims, all required fields must be completed on each page of the claim. Enter the page number and the total number of pages on the bottom of each claim page. For example, the first page would be numbered page 1 of 2, the second page, page 2 of 2.</p> <p>Outpatient: Florida Medicaid is collecting NDC information on Centers for Medicare and Medicaid Services designated, physician administered drugs in the outpatient hospital setting. The NDC is required on claims for drugs, including Medicare-Medicaid crossover claims for drugs. See the instructions below for entering the NDC.</p> <p>Freestanding Dialysis Centers: The NDC is required on claims for drugs, including Medicare-Medicaid crossover claims for drugs. See the instructions below for entering the NDC.</p> <p>Florida Medicaid will reimburse freestanding dialysis centers</p>

Form Locator	Title	Action
		<p>only for drugs for which the manufacturer has a federal rebate agreement per SEC. 1927. [42 U.S.C. 1396r-8]. The current list of manufacturers who have drug rebate agreements is available on AHCA's website at <a href="http://ahca.myflorida.com">http://ahca.myflorida.com</a>. Click on Medicaid, scroll down to "What is Occurring in Medicaid," and then click on "Current List of Drug Rebate Manufacturers."</p> <p>Instructions for Entering the NDC: When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug in Form Locator 43 for the specified detail line. Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units. The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer's labeler code, the middle four digits are the product code, and the last two digits are the package size. If you are given an NDC that is less than 11 digits, add the missing digits as follows:</p> <ul style="list-style-type: none"> <li>• For a 4-4-2 digit number, add a 0 to the beginning.</li> <li>• For a 5-3-2 digit number, add a 0 as the sixth digit.</li> <li>• For a 5-4-1 digit number, add a 0 as the tenth digit.</li> </ul> <p>Enter the Unit Qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. The Unit Qualifiers are:</p> <ul style="list-style-type: none"> <li>• F2 – International Unit</li> <li>• GR – Gram</li> <li>• ML – Millimeter</li> <li>• UN – Unit</li> </ul>
44	HCPCS/Rates/HIPPS Rate Codes	<p>Inpatient: Required for inpatient newborn hearing screening services. When revenue code 0471 is entered in Form Locator 42, enter the appropriate hearing screening CPT code that best describes the service rendered. They are 92585, 92587, 92585-TC, and 92587-TC. For details on inpatient procedure codes required with revenue codes 0360, 0361, 0722, 0750, and 0790, see the instructions for Form Locator 74.</p> <p>Outpatient: Enter the five-digit CPT-4 lab code from the Outpatient Hospital Laboratory Fee Schedule when billing for laboratory revenue codes (0300-0314). Do not bill radiology services with CPT codes. Radiology services performed by hospitals are billed by revenue code only. Revenue codes 0360, 0361, 0722, 0750, and 0790 require the entry of a HCPCS CPT procedure code. Revenue code 0471 requires the entry of one of the following newborn</p>

Form Locator	Title	Action
		<p>hearing screening codes in this form locator: 92585, 92587, 92588, 92585-TC, 92587-TC, or 92588-TC. Revenue code 0451 requires the entry of CPT code 99281 (emergency room screening and evaluation). Bill 0451 (99281) when the recipient had to be screened per EMTALA but required no further emergency room services. Centers for Medicare and Medicaid Services designated, physician administered drugs, for which the National Drug Code is reported, require the entry of the appropriate HCPCS code.</p> <p>Freestanding Dialysis Centers: Claims for the administration of Erythropoietin (Epogen, EPO) require the entry of the five-digit injection HCPCS code. When billing for drugs and biologicals, the 11-digit National Drug Code (NDC) is required in Form Locator 43 along with the five-digit HCPCS code in Form Locator 44. (See Form Locator 43 for details instructions on entering the 11-digit NDC on the claim.)</p> <p>Hospice: When billing revenue center code 0657, enter the corresponding five-digit CPT-4 code that is in the Florida Medicaid Hospice Coverage and Limitations Handbook. No other codes are covered.</p> <p>Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry is required.</p>
45	Service Date	<p>Required on outpatient claims.</p> <p>Lines 1–22: On each line, enter the date of service.</p> <p>Line 23: On each page, enter the date the bill was created or prepared for submission in MMDDYY format.</p>
46	Units of Service	<p>This form locator will accept up to seven characters. Leading zeros are not required.</p> <p>Inpatient: Enter the number of units of service and number of days for accommodations. A late discharge may not be billed as an additional day.</p> <p>Outpatient: Enter the units of service for each revenue code.</p> <p>Hospice: Enter the number of units of service for each type of service. Units are measured in days for codes 0651, 0655, 0656 and 0659; in hours for code 0652; and in procedures for 0657.</p> <p>Freestanding Dialysis Centers: Enter the units of service for the revenue center code(s). For revenue center codes 0821 and 0831, units are measured in the number of dialysis treatments the patient received in the billing period.</p> <p>Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the number of days associated with each revenue code. Medicaid reimburses the date of admission, but not the date of discharge. Include the date of admission, but do not include the date of discharge in the total number of days. If the recipient is admitted and discharged on the</p>

Form Locator	Title	Action
		same day, count it as one day.
47	Total Charges	<p>Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers: Enter the total charge for each revenue code or procedure code entry. This entry must be the sum of the individual charges.</p> <p>Line 23: Enter the total of all revenue code charges on the final page of the claim, along with revenue code 0001.</p> <p>Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the total charge for each revenue code or procedure code entry. This entry must be the sum of the individual charges. Do not deduct the patient responsibility.</p> <p>Line 23: Enter the total of all revenue code charges on the final page of the claim, along with revenue code 0001.</p> <p>For Medicare crossover claims (level of care X), compute the total charge using the Medicare rate instead of the Medicaid per diem. If the Medicare rate for a recipient changed during the month, use the weighted average Medicare rate (weighted based on the number of days each rate is paid).</p>
48	Non-Covered Charges	<p>Inpatient: No entry required.</p> <p>Outpatient, Hospice, and Freestanding Dialysis Centers: Enter the total payment received or expected to be received from a primary insurance payer identified in Form Locator 50A. Enter each portion of the payment applicable to each code in Form Locator 48. Enter the total amount payment received or expected to be received from a primary insurance payer on the final page of the claim in Line 23. If the primary insurance payer other than Medicare pays a lump sum payment, enter a prorated amount on each line. If there is more than one other private payer, lump all amounts together in Form Locator 48 and attach each company's Explanation of Benefits or remittance. Electronic software allows separate entries on an outpatient claim for primary, secondary, and tertiary payer payments. If billing on a paper claim and there is more than one private payer, attach documentation to show how much each payer paid for each line item.</p> <p>Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry is required.</p>
49	Unlabeled	No entry required

Form Locator	Title	Action
50A-C	Payer Name	Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter "Florida Medicaid" for the Medicaid payer identification. Enter the name of the third-party payer if applicable: <ul style="list-style-type: none"> <li>• 50A – Primary Payer</li> <li>• 50B – Secondary Payer</li> <li>• 50C – Tertiary Payer</li> </ul>
51A-C	Health Plan ID	For Medicaid, leave blank. If the health plan in Form Locator 50 has a number, report the number in 51 A, B or C depending on whether the insurance is primary, secondary or tertiary.
52A-C	Release of Information	Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Indicate whether the patient or patient's legal representative has signed a statement permitting the provider to release data to other organizations. The Release of Information is limited to the information carried in this claim. A = Primary B = Secondary C = Tertiary Code Structure: I = Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes. (Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.) Y = Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim. (Required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.)
53A-C	Assignment of Benefits	No entry required.
54A-C	Prior Payments	Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the amount that the provider has received toward payment of this bill prior to the billing date on this claim. Do not put the Medicaid amount due in this form locator. Inpatient and Outpatient: If no payment was received or if the service was denied, attach a copy of the EOB from the insurance carrier with the reason for the denial.
55A-C	Estimated Amount Due	No entry required.
56	NPI	The National Provider Identifier (NPI) is a unique HIPAA-mandated number assigned to the provider submitting the

Form Locator	Title	Action
		bill. The provider may enter either its NPI number in Form Locator 56 or its Medicaid provider number in Form Locator 57. If the provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Florida Medicaid claims processing system, the rendering provider must enter qualifier code B3 and the taxonomy code in Form Locator 81. Entry of the NPI on paper claims is optional. Florida Medicaid prefers that the provider continue to enter Medicaid provider numbers on paper claims.
57A-C	Other Provider ID	Use if an identification number other than NPI is being reported. The provider may enter either its NPI number in Form Locator 56 or its Medicaid provider number in Form Locator 57.
58A-C	Insured's Name	Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the insured's last name, first name, and middle initial exactly as it appears on the Medicaid ID card or other proof of eligibility. If the recipient is covered by insurance other than Medicaid, enter the name of the individual in whose name the insurance is carried.
59A-C	Patient's Relationship	Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter the code indicating the relationship of the patient to the identified insured. <ul style="list-style-type: none"> <li>• Line A: Primary Payer, Required</li> <li>• Line B: Secondary Payer, Situational</li> <li>• Line C: Tertiary Payer, Situational</li> </ul> Code Structure: <ul style="list-style-type: none"> <li>• 01 = Spouse</li> <li>• 18 = Self</li> <li>• 19 = Child</li> <li>• 21 = Unknown</li> </ul>
60A-C	Insured's Unique ID	Inpatient, Outpatient, Hospice, Freestanding Dialysis Centers, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter all of the insured's unique identification numbers assigned by any payer organizations. The recipient's ten-digit Medicaid ID number must be verified and entered. This entry must correspond with the Medicaid payer entry in Form Locators 50 A, B, or C. If Medicaid is primary, enter the recipient's Medicaid ID number in Form Locator 60A. If Medicaid is secondary, enter the recipient's Medicaid ID number in Form Locator 60B.
61A-C	Insurance Group Name	No entry required.

Form Locator	Title	Action
62A-C	Insurance Group Name	No entry required.
63A-C	Treatment Authorization Code	<p>Inpatient - MediPass: If a recipient under 21 is in the Children's Medical Services' (CMS) Network and the MediPass primary care physician authorized the services being billed, enter the nine-digit MediPass authorization number that was given to the hospital in Form Locator 63A. This number is different from the 10-digit prior authorization number issued by the PRO for inpatient services. If the recipient in the CMS Network is admitted due to an emergency, no MediPass authorization number is required in this form locator. This requires type of admission code 1 or 5 in Form Locator 14. A MediPass authorization number is not required for any type of inpatient admission for any other category of recipient, except for children in the CMS Network. If there is authorization from the PRO, enter the prior authorization number that covers the authorized days in Form Locator 63A, if Medicaid is the primary payer, or in Form Locator 63B, if Medicaid is the secondary payer. Most inpatient admissions require authorization from the PRO before Medicaid payment can be made. However, there are several exemptions from inpatient authorization. An exemption from authorization allows Medicaid to pay an inpatient claim without authorization from the PRO and without a prior authorization number on the claim form.</p> <p>Note: See Chapter 3 in this manual for information on the types of admissions and recipient categories that require inpatient authorization and the listing of recipient categories and circumstances that are exempt from authorization.</p> <p>Inpatient - Psychiatric or Substance Abuse: When the admitting and primary diagnosis code is in the range of 290–314.9 or 648.30–648.44, prior authorization by the psychiatric PRO is required. Enter the prior authorization number that covers this hospitalization in Form Locator 63A, if Medicaid is the primary payer, or in 63B, if Medicaid is the secondary payer.</p> <p>Note: See Chapter 3 in this manual for information on inpatient psychiatric or substance abuse authorization requirements.</p> <p>Outpatient: Outpatient services to recipients enrolled in MediPass require authorization from the MediPass primary care physician before services can be rendered, if the outpatient encounter is not an emergency. Enter the MediPass authorization number in Form Locator 63A if</p>



Form Locator	Title	Action
		<p>Medicaid is the primary payer or in 63B if Medicaid is the secondary payer. MediPass authorization is not required for true emergencies. This is indicated by the code entry of 1 or 5 for type of admission in Form Locator 14. It is also not required for Emergency Room Screening and Evaluation Services required by the Emergency Medical Treatment and Active Labor Act (EMTALA), billed using revenue code 0451 with HCPC (99281).</p> <p>Hospice: No entry required.</p> <p>Freestanding Dialysis Centers: No entry required.</p> <p>Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry required.</p>
64A-C	Document Control Number	No entry required. If the claim is an adjustment or void of a previously paid claim, enter the 13-digit Internal Control Number in Form Locator 80 on Line 2.
66	No entry required. If the claim is an adjustment or void of a previously paid claim, enter the 13-digit Internal Control Number in Form Locator 80 on Line 2.	<p>Enter the qualifier that identifies the version of the International Classification of Diseases (ICD) reported:</p> <ul style="list-style-type: none"> <li>• 9 – Ninth Revision</li> <li>• 0 – Tenth Revision</li> </ul>
67	Principal Diagnosis	<p>This Form Locator is optional; it is not entered in the Florida Medicaid Management Information System.</p> <p>Inpatient and Hospice: Enter the most specific fourth and fifth digit ICD code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization or need for hospice care) that exists at time of admission or develops subsequently that has an effect on the length of stay.</p> <p>Psychiatric admissions require the entry of a diagnosis in the range of 290-314.9 or 648.30-648.44 in this form locator and in Form Locator 69. A prior authorization number from the psychiatric PRO is required when the principal diagnosis is in the ranges noted here. If Medicaid is primary, the psychiatric PRO issued PA number is entered in Form Locator 63a; if Medicaid is secondary, the PA number is entered in Form Locator 63b.</p> <p>Outpatient: Enter only the most specific ICD code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing the use of hospital services that exists at time of service).</p> <p>Freestanding Dialysis Centers: Enter only the most specific ICD code describing the principal diagnosis for the condition chiefly responsible for causing the need for dialysis services. For example, diagnosis code 585.6 for end stage renal disease.</p>

Form Locator	Title	Action
		Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): Enter only the most specific ICD code describing the principal diagnosis for the condition chiefly responsible for causing the need for long term care.
67A-Q	Other Diagnoses	<p>Enter diagnoses that are other than the principle diagnosis. Inpatient: Enter the most specific ICD diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or developed subsequently and had an effect on the treatment received during the length of stay. Outpatient: Enter the most specific ICD diagnosis codes that correspond to additional conditions that co-exist at the time of service.</p> <p>Inpatient and Outpatient: Present on Admission (POA) Indicator: The POA Indicator applies to diagnosis codes, not only on the conditions known at the time of admission, but also include those conditions that were clearly present, but not diagnosed, until after the admission took place. Present on admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, are considered as present on admission. The POA indicator is applied to the principal diagnosis as well as all secondary diagnoses that are reported. The five reporting options for all diagnosis reporting are as follows:</p> <ul style="list-style-type: none"> <li>• Y = Yes</li> <li>• N = No</li> <li>• U = No Information in the Record</li> <li>• W = Clinically Undetermined</li> <li>• (Unreported—Not Used) = Exempt from POA Reporting</li> </ul> <p>Hospice: No entry required.</p> <p>Freestanding Dialysis Centers: Enter the most specific ICD diagnosis codes that correspond to additional conditions that co-exist at the time of service.</p> <p>Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry required.</p> <p>Special Circumstances When Diagnosis Codes are NOT Required on Outpatient Claims: Diagnosis codes are not required on outpatient claims when the type of bill is 141 (hospital-referenced diagnostic services) or when either of the following:</p> <ul style="list-style-type: none"> <li>• The only revenue center codes on the claim are in the range 0300–0307.</li> <li>• The only revenue center codes on the claim are any one or any combination of the following (with any Type of Admission code): 0310, 0311, 0312, 0314, 0320, 0321, 0322, 0323, 0324, 0340, 0341, 0400, 0401, 0402, 0460,</li> </ul>

Form Locator	Title	Action
		0610, 0611, 0612, 0730, 0731, 0740.
68	Unlabeled	No entry required.
69	Admitting Diagnosis	Inpatient: Required for all inpatient claims and claims with Type of Bills (Form Locator 4): 011X, 012X, 018X and 021X. The presence of an admitting diagnosis in 290–314.9, or 648.30–648.44 range, psychiatric or substance abuse, indicates that the inpatient services needed authorization by the psychiatric PRO. Outpatient: Required for outpatient to report the presenting symptom (diagnosis) and the reason for the patient's visit on claims that contain emergency services. Hospice, Freestanding Dialysis, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry required.
70 a-c	Patient's Reason for Visit Code	Outpatient: Enter the diagnosis codes describing the patient's reason at the time of the outpatient registration. This is required for all unscheduled outpatient visits as defined when the following occurs: Form Locator 4, Type of Bill 013X or 085X; Form Locator 14, Type of Admission codes 1, 2, or 5; and Form Locator 42, Revenue Codes 045X, 0516, 0526 or 0762 (Observation Room). Inpatient, Hospice, Freestanding Dialysis, and Long Term Care Facilities (Skilled Nursing Facilities and ICF/DDs): No entry required.
71	PPS Code	No entry required.

## TIMELY FILING

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

Providers shall submit to Humana all claims, and if capitated shall submit encounter data, for medical services rendered to Medicaid Managed Care Plan Members in accordance with the terms and conditions in the AHCA Contract. Notwithstanding anything to the contrary in the Agreement, Provider or Subcontractor agrees to submit such claims within 180 days from the date of service, or encounter data, as applicable, to Humana within 30 days from the date of service.

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

- [http://portal.flmmis.com/FLPublic/Provider\\_EDI/Provider\\_EDI\\_CompanionGuides/tabId/62/Default.aspx](http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_CompanionGuides/tabId/62/Default.aspx)
- [http://portal.flmmis.com/FLPublic/Provider\\_Pharmacy/tabId/52/Default.aspx](http://portal.flmmis.com/FLPublic/Provider_Pharmacy/tabId/52/Default.aspx)

## CLAIMS OVERPAYMENTS

Provider shall report to Humana when all claim overpayments for medical services rendered to Medicaid Managed Care Plan Members in accordance with the terms and condition in the AHCA Contract that have been received. Notwithstanding anything to the contrary in the agreement, Provider or Subcontractor agree to submit such claims within 60 days after the date on which the overpayment was identified, and to notify Humana in writing the reason for the overpayment as required by 42 CFR 438.608(d)(2). To be mailed to:

Humana Healthcare Plans  
P.O. Box 931655  
Atlanta, GA 31193-1655

## PAYMENT SUSPENSION

Humana shall pay nursing facility Providers in compliance with 42 CFR 488.417, and enforce any denial of payment for new admissions (DPNA) issued by the centers for Medicare & Medicaid Services.

## ERAS AND EFTS

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

- Sign into the secure provider website at [Humana.com/providers](https://www.humana.com/providers).
- Select the “ERA/EFT Setup-Change Request”.
- Complete the form.

You may also access the registration form from the public portal from the [Humana.com/providers](https://www.humana.com/providers) page:

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

Email questions to: [ebusiness@humana.com](mailto:ebusiness@humana.com).

## CROSSOVER CLAIMS

Effective Oct. 1, 2016, providers no longer need to send Medicare crossover claims for dually eligible recipients directly to Humana. Under this initiative, providers only need to submit their claims once to the Centers for Medicare & Medicaid Services (CMS) for processing and no longer are required to submit secondary claims to Humana. This means CMS will automatically forward claims for members who are dually eligible for both Medicare and Medicaid coverage. Please note: If a provider submits a claim for a dually eligible member that CMS already has forwarded to Humana, Humana will deny the provider-submitted claim as a duplicate claim.

**INCENTIVE PLANS**

Upon request, the physician agrees to disclose to Humana within a reasonable time frame not to exceed 30 days, or such lesser period of time required for Humana to comply with all applicable state and federal laws, rules and regulations, from such request, all of the terms and conditions of any payment arrangement that constitutes a physician incentive plan as defined by CMS and/or any state or federal law, between physician and other physicians. Such disclosure shall be in the form of a certification, or other form as required by CMS and/or AHCA, by the physician and shall contain information necessary for Humana to comply with applicable state and federal laws, rules and regulations and as requested by Humana.

Within 35 days of a request by AHCA or DHHS, physician shall disclose physician's ownership; any significant business transactions between physician and any wholly owned supplier or subcontractor during the five year period ending on the date of the request; and the identity of any owner, agent or managing employee of the physician who has been convicted of a crime relating to any program under Medicare, Medicaid or the Title XX services program.

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## CULTURAL COMPETENCY PLAN

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

Participating providers must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.

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

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

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

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

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

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## MEMBER RIGHTS AND RESPONSIBILITIES

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### MEMBER RIGHTS

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

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

### **MEMBER RESPONSIBILITIES**

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



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## FRAUD AND ABUSE POLICY

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

Physician understands and agrees to educate physician's employees about the False Claims Act's prohibition on submitting false or fraudulent claims for payment, penalties for false claims and statements, whistleblower protections and each person's responsibility to prevent and detect fraud, waste and abuse.

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

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

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

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

In addition, providers may use the following contacts:

### Telephonic:

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

Email: [siureferrals@humana.com](mailto:siureferrals@humana.com) or [ethics@humana.com](mailto:ethics@humana.com)

Web: [Ethicshelpline.com](http://Ethicshelpline.com)

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## HEALTH, SAFETY AND WELFARE

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

- **Abuse** — Non-accidental infliction of physical and/or emotional harm.
- **Physical Abuse** — Causing the infliction of physical pain or injury to person.
- **Sexual Abuse** — Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities; touching, fondling, sexual threats, sexually inappropriate remarks or any other sexual activity with a person when the person is unable to understand, unwilling to consent, threatened or physically forced to engage in sexual activity.
- **Psychological Abuse** — Includes, but is not limited to, name calling, intimidation, yelling and swearing. May also include ridicule, coercion and threats.
- **Emotional Abuse** — Verbal assaults, threats of maltreatment, harassment or intimidation intended to compel the older person to engage in conduct from which he or she wishes and has a right to abstain, or to refrain from conduct in which the older person wishes and has a right to engage.
- **Neglect** — Repeated conduct or a single incident of carelessness that results or could reasonably be expected to result in serious physical or psychological/emotional injury or substantial risk of death (this includes self-neglect and passive neglect).
- **Exploitation** — Illegal use of assets or resources of an adult with disabilities. It includes, but is not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion or in any manner contrary to law.
- **Human Trafficking** — Includes, but is not limited to
  - A scripted or inconsistent history
  - Unwilling or hesitant to answer questions about the injury or illness
  - Accompanied by an individual who does not let the patient speak for themselves, refuses to let the patient have privacy, or who interprets for them
  - Evidence of controlling or dominating relationships (excessive concerns about pleasing a family member, romantic partner, or employer)
  - Demonstrates fearful or nervous behavior or avoids eye contact
  - Resistant to assistance or demonstrates hostile behavior
  - Unable to provide his/her address
  - Not aware of his/her location, the current date or time
  - Not in possession of his/her identification documents
  - Not in control of his or her own money
  - Not being paid or wages are withheld

## **Indicators of Abuse, Neglect and Exploitation**

### **Physical indicators**

1. Unexplained bruises or welts:
  - On face, lips, mouth, torso, back, buttocks, thigh in various stages of healing
  - Reflecting shape of article used to inflict (electric cord or belt buckle) in several different surface areas
2. Unexplained fractures:
  - To skull, nose, facial structure, in various stages of healing
  - Multiple or spiral fractures
3. Unexplained burns:
  - Cigar, cigarette burns, especially on palms, legs, arms, back or soles of feet
  - Immersion burns (sock like, glove like, doughnut shaped on buttocks)
  - Patterned like objects (electric burner, etc.)
4. Unexplained lacerations:
  - Mouth, lips, gums, eye or to external genitalia
5. Sexual abuse:
  - Difficulty in walking/sitting
  - Torn, shredded or bloody undergarments
  - Bruises or bleeding in external genitalia, vaginal or anal areas
  - Venereal disease
  - Pregnancy
6. Other:
  - Severe or constant pain
  - Obvious illness that requires medical or dental attention
  - Emaciated (so that individual can hardly move or so thin bones protrude)
  - Unusual lumps, bumps or protrusions under the skin
  - Hair thin as though pulled out, bald spots
  - Scars
  - Lack of clothing
  - Same clothing all of the time
  - Fleas, lice on individual
  - Rash, impetigo, eczema
  - Unkempt, dirty
  - Hair matted, tangled or uncombed

### **Behavioral indicators**

1. Destructive behavior of victim:
  - Assaults others
  - Destroys belongings of others or themselves
  - Threatens self-harm or suicide
  - Inappropriately displays rage in public

- Steals without an apparent need for the things stolen
  - Recent or sudden changes in behavior or attitudes
2. Other behavior of victim:
- Afraid of being alone
  - Suspicious of other people and extremely afraid others will harm them
  - Shows symptoms of withdrawal, severe hopelessness, helplessness
  - Constantly moves from place to place
  - Frightened of caregiver
  - Overly quiet, passive, timid
  - Denial of problems
3. Behavior of family or caregiver
- Marital or family discord
  - Striking, shoving, beating, name-calling, scapegoating
  - Hostile, secretive, frustrated, shows little concern, poor self-control, blames adult, impatient, irresponsible
  - Denial of problems
  - Recent family crisis
  - Inability to handle stress
  - Recent loss of spouse, family member or close friend
  - Alcohol abuse or drug use by family
  - Withholds food, medication
  - Isolates individual from others in the household
  - Lack of physical, facial, eye contact with individual
  - Changes doctor frequently without specific cause
  - Past history of similar incidents
  - Resentment, jealousy
  - Unrealistic expectations of individual

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

The "Adult Abuse, Neglect and Exploitation Guide for Professionals" may be used as a training tool. It is available at: <http://www.dcf.state.fl.us/programs/aps/docs/GuideforProfessionals.pdf>.

Suspected elder abuse, neglect, or exploitation may be reported 24 hours a day, seven days a week to the central abuse hotline at **1-800-96-ABUSE (1-800-962-2873)**. Online reports may be filed at: [www.Dcf.State.Fl.Us/abuse/report/index.asp](http://www.Dcf.State.Fl.Us/abuse/report/index.asp).

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

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

## ADVERSE INCIDENT REPORTING

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

### Participating providers should:

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

[Critical Incident Report](#)

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## PATIENT-CENTERED MEDICAL HOME (PCMH)

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

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

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

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

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

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

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

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

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

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

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

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

PCPs who are interested in the PCMH program, certification requirements and the benefits may email [pcmh@humana.com](mailto:pcmh@humana.com).

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## MEDICAID ADVISORY PANEL

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

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

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



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## PROVIDER REWARDS AND INCENTIVES

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

**Eligibility:**

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

**MMA Physician Incentive Program (MPIP)**

The MMA Physician Incentive Program's aim is to promote quality of care for Medicaid members and recognize those physicians who demonstrate high levels of performance for selected criteria. The MPIP provides the opportunity for designated physician types to earn enhanced payments equivalent to the appropriate Medicare fee-for-service rate, as established by the AHCA based on the achievement of key access and quality measures. *To learn more about this program, including whether you qualify, please contact your provider contracting representative.*

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

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## PROVIDER RESOURCE WEBSITE

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Providers may obtain plan information from [Humana.com/providers](https://www.humana.com/providers).

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

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

Why register for **Humana.com**?

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

Humana created a website specific to Florida Medicaid containing resources and updates for providers, viewable at [humana.com/provider/support/clinical/medicaid-materials/florida](https://www.humana.com/provider/support/clinical/medicaid-materials/florida).

For help or more information regarding Web-based tools, email [ebusiness@humana.com](mailto:ebusiness@humana.com).

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## PROVIDER TRAINING

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

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

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

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

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

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

Additional provider training: Visit [Humana.com/providers](https://www.humana.com/providers) and choose "Web-based Training Schedule" under "Critical Topics."

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## AVAILITY

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

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

To learn more, call **1-800-282-4548** or visit [www.Availity.com](http://www.Availity.com).

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## HELPFUL NUMBERS

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

- Prior authorization (PA) assistance for medical procedures: 1-800-523-0023, 8 a.m. – 8 p.m. Eastern time, Monday – Friday
- Prior authorization for medication billed as medical claim: 1-866-461-7273, 8 a.m. – 6 p.m. Eastern time, Monday – Friday
- Prior authorization for pharmacy drugs: 1-800-555-2546, 8 a.m. – 6 p.m. local time, Monday – Friday
- Medicare/Medicaid case management: 1-800-322-2758
- Medicare/Medicaid concurrent review: 1-800-322-2758
- Clinical management program information: 1-800-491-4164
- PrescribeIT: 1-800-526-1490
- Availity customer service/tech support: 1-800-282-4548
- Ethics and compliance concerns: 1-877-5-THE-KEY (1-877-584-3539)

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

- **Baby Well Visit** — Member enrolls by calling **1-800-611-1467** and completing three well-baby visits before 18 months of age. They'll receive a \$10 gift card per visit, up to three after the provider claim is validated by Humana (up to three rewards totaling \$30).
- **Pediatric Well Visit** — Member enrolls annually by calling **1-800-611-1467** and completing a well-child visit. They'll receive a \$20 gift card after the provider claim is validated by Humana (up to one reward of \$20 per year).
- **Humana Family Fit** — Members 18 years and older can be self-, plan- or provider-referred by calling Humana Wellness Solutions at **1-855-330-8053**. Once enrolled in the six-month program, Humana will offer the member the following optional intervention tools:
  - Monthly newsletters with articles and activities to help them stay motivated
  - Nutritional counseling to help them with their diet

Once the member completes an initial well visit with their PCP at enrollment, they will be rewarded with a weight scale (one per lifetime). At the end of the program (180 days), if they complete another well visit with their PCP, Humana will reward them with a \$30 gift card. (\$30 is the maximum reward, per enrolled member, per lifetime.)

- **Mom's First Prenatal and Postpartum** — Members can be self-, plan- or provider-referred by calling **1-800-322-2758, ext. 1500290** and completing all prenatal and postpartum visits with their provider; they'll receive a \$30 gift card (up to one reward of \$30 per pregnancy).
- **Smoking Cessation** — Members 18 years and older can be self-, plan- or provider-referred by calling Beacon Health Options at **1-800-221-5487**. Once enrolled in the six-month program, members are eligible for a \$15 gift card for completing 90 days in the program and another \$15 gift card for completing 180 days. Or if the member completes the program using a drug prescribed by their PCP to help them stop smoking, Humana will reward them with a \$20 gift card at 90 days and another \$20 gift card at program completion (180 days). (\$40 is the maximum reward, per enrolled member, per year.)
- **Substance Abuse** — Members 18 years and older can be self-, plan- or provider-referred by calling Beacon Health Options at **1-800-221-5487**. Members will receive a \$10 gift card for enrolling in the six-month program. Then at 90 days of sobriety, they receive a \$20 gift card. At 180 days of sobriety, they'll receive another \$20 gift card and will complete the program (up to three rewards totaling \$50).

You can find related materials here: [humana.com/provider/support/clinical/medicaid-materials/florida](https://www.humana.com/provider/support/clinical/medicaid-materials/florida).

## SECTION II – HUMANA LONG-TERM CARE/HUMANA COMPREHENSIVE PLAN

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### INTRODUCTION

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If you have a patient/member who is enrolled in both Humana's MMA plan and LTC plan, the plan name is **Humana Comprehensive Plan**. Humana Comprehensive Plan covers both medical and long-term care services. A patient/member who is enrolled in a Medicare Dual Eligible Special Needs Plan (DSNP) can receive long-term care services from Humana Long-term Care Plan.

Section I of this manual, Humana Medical Plan, describes information for providers who are rendering medical services.

Section II of this manual, Humana Long-term Care/Humana Comprehensive Plan, describes information for providers who are rendering long-term-care services.

Humana's long-term-care managed care plan works directly with the state of Florida to provide our members with community and/or facility care with a focus to coordinate the member's primary care through his/her primary insurance. Humana is a statewide contractor for this program, allowing our membership to freely move to any county they choose in the state.

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

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

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

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

## STATEWIDE MEDICAID MANAGED CARE (SMMC)

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

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

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

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

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

Medicaid recipients who qualify and become enrolled in the Florida Long-term Care Managed Care program will receive long-term care services through a comprehensive managed care plan or a long-term care plus managed care plan. Humana is a comprehensive managed care plan approved in all 11 regions of the state of Florida to provide medical and long-term-care services to eligible enrollees.

Medicaid recipients who qualify and become enrolled in the Florida Managed Medical Assistance program will receive all Healthcare services other than long-term care through a managed care plan. All Humana Comprehensive Plan members will be enrolled in Humana's comprehensive managed care plan, and Humana will be responsible for providing long-term care services, medical services as well as coordinating Medicare benefits if the recipient is dual eligible.

For more information on the Florida Long-term Care Managed Care program, please visit the AHCA website at: [http://ahca.myflorida.com/Medicaid/statewide\\_mc/index.shtml](http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml).

## LONG-TERM-CARE MANAGED CARE PROGRAM

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

The long-term-care managed care program is designed to care for all eligible individuals over the age of 18 who meet a level of care that requires nursing home care, as well as a financial criterion; both qualifications are determined by the state. The program provides eligible individuals with access to care



in a nursing home or a less restrictive environment in the community. The program seeks to reduce the number of individuals residing in nursing homes so they may be cared for in less-restrictive environment while also creating cost savings for the state.

## **PRACTICE GUIDELINES**

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

Practice guideline requirements are designed with the following in mind:

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

## **MISSION STATEMENT**

We provide the highest quality services to our members by a team of motivated, invested associates and leaders, driving outstanding customer experiences while pioneering simplicity and exceeding stakeholder expectations. Thriving together to achieve positive outcomes through innovative solutions and best practices.

## **HOURS OF OPERATION**

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

## **HUMANA LONG-TERM CARE COMPREHENSIVE PLAN WEBSITE**

[Humana.com/Humanalongtermcare](https://www.humana.com/Humanalongtermcare)

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

## **CONFIDENTIALITY STATEMENT**

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

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## ELIGIBILITY

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

### CONDITIONS OF ENROLLMENT

Recipients eligible for enrollment must:

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

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

### MEDICAID PENDING

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

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

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

## MEMBERSHIP IDENTIFICATION (ID) CARD

Each member receives a Humana Comprehensive Plan member identification (ID) card. If the card is lost or stolen, the member may contact his or her care manager. Members can also access their ID card through the MyHumana website or MyHumana mobile app. Sample member ID card is below.

<p><b>Humana.</b></p> <p><b>Humana Comprehensive Plan</b></p> <p><b>MEMBER NAME</b>  <b>Member ID: HXXXXXXXXX</b></p> <p>Medicaid ID#: XXXXXXXX      Group #: XXXXXXXX  Date of Birth: XX/XX/XX      RxBIN: 610649  Effective Date: XX/XX/XX      RxPCN: 03190000</p> <p>PCP Name: XXXXXXXXX  PCP Phone: (XXX) XXX-XXXX  Primary Care Address: XXXXXXXXXXXX</p>	<p>Member/Provider Service: 1-888-998-7732  Member Behavioral Health Inquiries: 1-888-778-4651  Pharmacist Rx Inquiries: 1-800-865-8715  Provider Prior Authorization: 1-800-523-0023  Provider Long-Term Care Inquiries: 1-888-998-7735</p> <p><b>For online provider services, go to [www.availity.com]</b></p> <p>Please mail all claims to:  <b>Managed Medical Assistance      Long Term Care</b>  <b>Humana Medical      Humana Long Term Care</b>  <b>P.O. Box 14601      P.O. Box 14732</b>  <b>Lexington, KY 40512-4601      Lexington, KY 40512-4732</b></p>
<p><b>Humana.</b></p> <p><b>Humana Long-Term Care Plan</b></p> <p><b>MEMBER NAME</b>  <b>Member ID: HXXXXXXXXX</b></p> <p>Medicaid ID: XXXXXXXXXX  Group #: XXXXXXXX</p>	<p>Member Long-Term Care Inquiries: 1-888-998-7732  Provider Long-Term Care Inquiries: 1-888-998-7735</p> <p><b>For online provider services, go to [www.availity.com]</b></p> <p><b>For Participating and Non-Participating Providers Send Claims to:</b>  <b>Humana Long Term Care</b>  <b>P.O. Box 14732</b>  <b>Lexington, KY 40512-4732</b></p>

## REFERRALS TO HUMANA LONG-TERM CARE/HUMANA COMPREHENSIVE PLAN

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

## MEMBER DISENROLLMENT

### Disenrollment with cause

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

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

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

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

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

#### **A member has the option to disenroll without cause**

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

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

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

## COVERED SERVICES

Humana Comprehensive Plan provides coverage for members who are enrolled in our Long-Term Care Managed Care Program and our Managed Medical Assistance Program. Please refer to Section I Humana Medical Plan for providers who are rendering medical services. Long-Term care coverage is limited to those services authorized in writing by the member's care manager and in accordance with the Agency for Healthcare Administration Medicaid Services Coverage and Limitations handbooks. Covered services include:

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

### MEDICALLY NECESSARY/MEDICAL NECESSITY

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

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
- Be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker or the provider.

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

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

## **EMERGENCY SERVICE RESPONSIBILITIES**

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

## **ADULT DAY CARE (ADC)**

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

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

## **ASSISTIVE CARE**

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

- 24-hour access to staff
- Assistance with ambulation
- Assistance with transferring
- Assistance with eating
- Dementia care
- Dressing and grooming



- Emergency/disaster plan
- Escort services
- Housekeeping
- Incontinence management
- Medication management
- Personal laundry and linen services
- Three meals per day, plus snacks
- Transportation
- Utilities
- Wander guard

### **ASSISTED LIVING FACILITY (ALF)**

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

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

**Transportation** — All Humana Comprehensive Plan contracts with ALFs require the ALF to coordinate transportation for members. Humana Comprehensive Plan members are eligible for transportation trips to long-term-care-covered services as authorized by Humana. Please contact the enrollee’s care manager for authorization approval. Our members will use their health plan ID card for all covered transportation services (including emergency transportation).

## **BEHAVIORAL MANAGEMENT**

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

## **HOME ACCESSIBILITY ADAPTATION SERVICES**

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

Members or caregivers will be contacted within two business days of receipt of authorization from the Humana Comprehensive Plan care manager to schedule an appointment.

## **HOME-DELIVERED MEALS**

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

## **HOME HEALTHCARE (HHC)**

Providers contracted with the Humana Comprehensive Plan must adhere to the following procedures when providing services:

- Humana reserves the right to determine the plan of care for its members and will send a request of specific services and frequency to meet the member's needs. Services may be provided in a member's home or an assisted living facility on an hourly or per-visit fee as authorized by Humana. The HHC provider has a maximum of two hours to inform Humana Comprehensive Plan staff if the requested services can be provided and the anticipated start date.
- HHC staff are required to have the agency's designated form signed by the member verifying that the services were provided at the time of each visit, including date/time of service and direct care staff who provided the service.
- In compliance with the 21<sup>st</sup> Century CURES Act, providers are required to utilize electronic visit verification (EVV) to electronically monitor, track, and confirm services provided in the home setting.
- If a Humana Comprehensive Plan member is entitled to Medicare home health benefits, these benefits will be utilized prior to services being authorized under your contract with the Humana Comprehensive Plan.

Home health services are authorized by the care manager on a weekly basis (Sunday through Saturday). Preauthorization is required by the care manager to provide services that exceed the number of hours

authorized in a day or in a week. The only variation that is allowable without preauthorization is to switch the days of services within the same week, with prior authorization of the member. If the schedule change is permanent, the provider should inform the care manager of the change.

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

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

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

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

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

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

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

## HOSPICE

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

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

## MEDICAL SUPPLIES (CONSUMABLE)

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

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

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

## MEDICAL SUPPLIES (DURABLE MEDICAL EQUIPMENT)

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

## SKILLED NURSING FACILITY (SNF) SERVICES

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

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

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

**Respite care** — Respite care provides caregivers with relief for short periods of time. Respite care may be provided by a SNF. Respite care is not a substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist.

**Transportation** — All Humana Comprehensive Plan contracts with SNFs require the SNF to coordinate transportation for our members. Humana Comprehensive Plan members are eligible for transportation

to long-term-care-covered services, as authorized by Humana. Please contact the member's care manager for authorization approval. Our members will use their health plan ID card for all covered transportation services (including emergency transportation).

**Change in member's needs** — Providers will inform Humana Comprehensive Plan staff of changes or concerns they identify while providing services to members to ensure that members' needs are being met. This includes notification of members being admitted to a hospital and/or going to a Medicare or Medicaid hospice program. Medicaid hospice services require preauthorization from Humana. Notification must be provided within 24 hours of a significant change in members' Healthcare needs.

**Custodial care** — All members requiring this service must be assessed and a determination must be made by Humana that the member no longer can live in a less restrictive setting. Members who receive approval for placement in a contracted skilled nursing facility for custodial care are required to pay the facility a patient responsibility amount based on their income, which is determined by the Department of Children and Families. Prior authorization is required by Humana.

## **NUTRITIONAL ASSESSMENT/RISK REDUCTION**

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

## **PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)**

This includes the installation and service of an electronic device that enables members at high risk of institutionalization to secure help in an emergency. The PERS is connected to the member's phone and programmed to signal a response center once a "help" button is activated. The member also may wear a portable "help" button to allow for mobility. PERS services generally are limited to those members who live alone or are alone for a significant part of the day and who otherwise would require extensive supervision. Providers will train Humana Comprehensive Plan members on the use and monthly testing of the unit upon installation and will notify Humana via telephone or fax if a member utilizes the system.

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

## **PHARMACY BENEFITS**

The Humana Comprehensive Plan provides over-the-counter (OTC) medication benefit for our members. This benefit is obtained through our mail-order pharmacy. Our OTC order form is available upon request. Refer to the member handbook for additional information.

## **TRANSPORTATION**

Humana Comprehensive Plan members are eligible for transportation to long-term-care-covered services, as authorized by Humana. Please contact the plan for authorization approval. Our members will use their health plan ID card for all covered transportation services (including emergency transportation).

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

## **QUALITY ENHANCEMENTS**

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

## **EXPANDED SERVICES**

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

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

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## CARE MANAGEMENT

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

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

Care managers can assist members with:

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

### AUTHORIZATIONS

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

#### Procedures for authorization of services

- Upon determination that a member needs services from a facility or company, the care management team will contact the provider to inquire if the services can be provided and provide an authorization. The authorization is valid for the period of time specified or otherwise indicated on the authorization. If dates of services are not established, the provider's staff is responsible for following up with the plan with the date that services will begin.
- If a member needs to stop services for a short period of time (e.g., due to a hospitalization), the care management team will fax an updated authorization to the provider.
- If a member no longer needs services from the provider, the care management team will fax a termination of services authorization to the provider.

- If a member needs an increase or decrease in services, the care management team will fax an updated authorization to the provider.

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

## HEALTH, SAFETY AND WELFARE

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

- **Abuse** — Non-accidental infliction of physical and/or emotional harm.
- **Physical Abuse** — Causing the infliction of physical pain or injury to an older person.
- **Sexual Abuse** — Unwanted touching, fondling, sexual threats, sexually inappropriate remarks or other sexual activity with an adult with disabilities; touching, fondling, sexual threats, sexually inappropriate remarks or any other sexual activity with an older person when the older person is unable to understand, unwilling to consent, threatened or physically forced to engage in sexual activity.
- **Psychological Abuse** — Includes, but is not limited to, name calling, intimidation, yelling and swearing. May also include ridicule, coercion and threats.
- **Emotional Abuse** — Verbal assaults, threats of maltreatment, harassment or intimidation intended to compel the older person to engage in conduct from which he or she wishes and has a right to abstain, or to refrain from conduct in which the older person wishes and has a right to engage.
- **Neglect** — Repeated conduct or a single incident of carelessness that results or could reasonably be expected to result in serious physical or psychological/emotional injury or substantial risk of death (this includes self-neglect and passive neglect).
- **Exploitation** — Illegal use of assets or resources of an adult with disabilities. It includes, but is not limited to, misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion or in any manner contrary to law.
- **Human Trafficking** — Includes, but is not limited to:
  - A scripted or inconsistent history
  - Unwilling or hesitant to answer questions about the injury or illness
  - Accompanied by an individual who does not let the patient speak for themselves, refuses to let the patient have privacy, or who interprets for them
  - Evidence of controlling or dominating relationships (excessive concerns about pleasing a family member, romantic partner, or employer)
  - Demonstrates fearful or nervous behavior or avoids eye contact
  - Resistant to assistance or demonstrates hostile behavior
  - Unable to provide his/her address
  - Not aware of his/her location, the current date or time
  - Not in possession of his/her identification documents
  - Not in control of his or her own money
  - Not being paid or wages are withheld



## INDICATORS OF ABUSE, NEGLECT AND EXPLOITATION

### Physical indicators

1. Unexplained bruises or welts:
  - On face, lips, mouth, torso, back, buttocks, thigh in various stages of healing
  - Reflecting shape of article used to inflict (electric cord or belt buckle) in several different surface areas
2. Unexplained fractures:
  - To skull, nose, facial structure, in various stages of healing
  - Multiple or spiral fractures
3. Unexplained burns:
  - Cigar, cigarette burns, especially on palms, legs, arms, back or soles of feet
  - Immersion burns (sock-like, glove-like, doughnut-shaped on buttocks)
  - Patterned like objects (electric burner, etc.)
4. Unexplained lacerations:
  - Mouth, lips, gums, eye or to external genitalia
5. Sexual abuse:
  - Difficulty in walking/sitting
  - Torn, shredded or bloody undergarments
  - Bruises or bleeding in external genitalia, vaginal or anal areas
  - Venereal disease
  - Pregnancy
6. Other:
  - Severe or constant pain
  - Obvious illness that requires medical or dental attention
  - Emaciated (so that individual can hardly move or so thin bones protrude)
  - Unusual lumps, bumps or protrusions under the skin
  - Hair thin as though pulled out, bald spots
  - Scars
  - Lack of clothing
  - Same clothing all of the time
  - Fleas, lice on individual
  - Rash, impetigo, eczema
  - Unkempt, dirty
  - Hair matted, tangled or uncombed

### Behavioral indicators

1. Destructive behavior of victim:
  - Assaults others
  - Destroys belongings of others or themselves
  - Threatens self-harm or suicide
  - Inappropriately displays rage in public

- Steals without an apparent need for the things stolen
  - Recent or sudden changes in behavior or attitudes
2. Other behavior of victim:
- Afraid of being alone
  - Suspicious of other people and extremely afraid others will harm them
  - Shows symptoms of withdrawal, severe hopelessness, helplessness
  - Constantly moves from place to place
  - Frightened of caregiver
  - Overly quiet, passive, timid
  - Denial of problems
3. Behavior of family or caregiver
- Marital or family discord
  - Striking, shoving, beating, name-calling, scapegoating
  - Hostile, secretive, frustrated, shows little concern, poor self-control, blames adult, impatient, irresponsible
  - Denial of problems
  - Recent family crisis
  - Inability to handle stress
  - Recent loss of spouse, family member or close friend
  - Alcohol abuse or drug use by family
  - Withholds food, medication
  - Isolates individual from others in the household
  - Lack of physical, facial, eye contact with individual
  - Changes doctor frequently without specific cause
  - Past history of similar incidents
  - Resentment, jealousy
  - Unrealistic expectations of individual

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

You may use the "Adult Abuse, Neglect and Exploitation Guide for Professionals" as a training tool. It is available at: <http://www.dcf.state.fl.us/programs/aps/docs/GuideforProfessionals.pdf>.

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

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

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

## **CRITICAL INCIDENT REPORTING**

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

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

### **Participating providers should:**

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

[Critical Incident Report](#)

## MEMBER RIGHTS AND RESPONSIBILITIES

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

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

Members also have the right:

- To be fully informed in advance of all care and treatment to be provided by the service provider, changes in care or treatment and to receive a copy of their plan of care if they request.
- To be fully informed of services available from the service provider and how to access care.
- To be fully informed by a physician of health status, unless medically contraindicated.
- To be afforded the opportunity to participate in the development of the care plan and to refuse treatment without retribution, while being fully informed of the possible medical consequences of refusal.
- To be assured of the confidentiality of records and to approve or refuse the release of information not authorized by law.
- To be treated with consideration, respect, full recognition of dignity and individuality, including privacy in treatment and in care for personal needs; to have property treated with respect.
- To file a grievance without fear of discrimination or reprisal from the service provider.
- To be informed of the state hotline number with hours of operation and purpose for obtaining information on home health agencies.
- To be assured that qualified personnel will present proper identification at the time of a visit.
- To be served without regard to race, color, creed, sex, age, national origin, ancestry or handicap/disability.
- To be advised — before care is initiated — of the cost of services and the extent to which payment may be required by the patient.
- To receive home and community-based services in a home-like environment and participate in their communities regardless of their living arrangements.
- To direct their care with their own staff and/or providers.

Members have a responsibility:

- To provide accurate and complete medical and health history information as they understand it.
- To participate with the plan of treatment, when possible, and make available an informal caregiver to assume primary care, as appropriate.
- To have a primary care physician who will provide orders (as required) for skilled home-care treatments and services.
- To inform the service provider about changes in health status, medications or treatments.

- To inform the agency of any change in financial status that may affect reimbursement for home care.
- To have a plan for management of emergencies and to access the plan, if necessary for safety.
- To inform the service provider of the presence of advance directives and provide copies, as appropriate.
- To accept services of service provider staff, without regard to race, creed, color, religion, national origin, handicap, sex or age.
- To report fraud, abuse and overpayment.
- To file a report of suspected fraud and/or abuse in Florida Medicaid:
  - Call the Consumer Complaint Hotline toll free at **1-888-419-3456**.
  - Call the Florida general hotline at **1-866-966-7226**.
  - Call the Special Investigations hotline at **1-877-217-9717**.
  - Complete a Medicaid fraud and abuse complaint form, which is available online at:  
<https://apps.ahca.myflorida.com/mpi-complaintform/>

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

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## PROVIDER RESPONSIBILITIES

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

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

### CREDENTIALING COMMITTEE

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

### INITIAL CREDENTIALING

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

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

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

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

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

## RECREREDENTIALING

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

## PROVIDER MONITORING

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

## RIGHT TO REVIEW AND CORRECT INFORMATION

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

## **RIGHT TO APPEAL ADVERSE CREDENTIALING DETERMINATIONS**

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

## **NATIONAL PROVIDER IDENTIFIER (NPI)**

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

## **FLORIDA MEDICAID PROVIDER NUMBER**

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

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

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

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

- A Healthcare provider may not have a "fully enrolled" or "straight" Medicaid ID that is active. Managed care organization (MCO) numbers are no longer accepted. Healthcare providers need to apply for a "straight" Medicaid ID, or what is sometimes referred to as a "fully enrolled" Medicaid ID.
- A Healthcare provider may not have a "fully enrolled" or "straight" Medicaid ID under the provider's own name and National Provider Identifier (NPI) for each specialty he or she practices. If a Healthcare provider is practicing more than one specialty, he or she needs to have a Medicaid ID for each specialty.



## PROVIDER ORIENTATION AND EDUCATION

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

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

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

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

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

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

## NOTICE OBLIGATION

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

**Changes in your office** — Notify your provider contracting representative immediately of changes in your office, such as:

- Physical address change
- Tax identification/billing address change (W-9 required)
- Demographic changes (e.g., telephone, fax, email or administrative staff changes)
- New patient indicator
- Name and ownership change (35-day notice)

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

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

## PROVIDER DIRECTORY

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

## PARTICIPATING AGREEMENT STANDARDS

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

## ACCESSIBILITY AND AVAILABILITY

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

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

## PROVIDER SATISFACTION SURVEY

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

## QUALITY IMPROVEMENT REQUIREMENTS

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

- **Performance improvement projects (PIPs)** — Ongoing measurements and interventions, significant improvement to the quality of care and service delivery, sustained over time, in both clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.
- **Medical Record Audits** — Medical record reviews to evaluate patterns of complaints regarding poor quality of service, poor quality outcomes, and adherence to enrollee record documentation standards.
- **Performance measures** — Data collected on patient outcomes as defined by the Healthcare Effectiveness Data and Information Set (HEDIS®) or otherwise defined by the agency.
- **Surveys** — Consumer Assessment of Health Plans Surveys (CAHPS®)
- **Peer Review** — Reviews of provider's practice methods and patterns and appropriateness of care.

### **Standards for enrollee records:**

- Include the enrollee's identifying information, including name, enrollee identification number, date of birth, gender, and legal guardianship (if any);
- Include information relating to the enrollee's use of tobacco, alcohol, and drugs/substances;
- Include summaries of all emergency services and care and hospital discharges with appropriate, medically indicated follow up;
- Reflect the primary language spoken by the enrollee and any translation needs of the enrollee;
- Identify enrollees needing communication assistance in the delivery of Healthcare services;
- Include copies of any completed consent or attestation form(s) used by the Managed Care Plan or court order for prescribed psychotherapeutic medication for a child under the age of 13 years;
- All enrollee records shall contain documentation that the enrollee was provided with written information concerning the enrollee's rights regarding advance directives (written instructions for living will or power of attorney), including information on Chapter 765, F.S., and whether or not the enrollee has executed an advance directive. (42 CFR 438.3(j)(3))
- Neither the managed care plan, nor any of its providers shall, as a condition of treatment, require the enrollee to execute or waive an advance directive. (42 CFR 438.3(j)(1)-(2); 42 CFR 422.128(b)(1)(ii)(H); 42 CFR 489.102(a)(5))

### **TERMINATION OF PROVIDER CONTRACT**

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

Humana Long-term Care Plan  
 Attention: Provider Contracting Department  
 777 Yamato Road, Suite 510  
 Boca Raton, FL 33487

### **OUT-OF-NETWORK/NONCONTRACTED SERVICES**

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

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

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

## **MINORITY RECRUITMENT AND RETENTION PLAN**

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

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

### **Native Americans**

Humana does not impose enrollment fees, premiums or similar charges on Native Americans served by a Native American Healthcare provider; Native American health service, a Native American tribe, tribal organization or urban Indian organization; or through referral under contract health services, in accordance with the American Recovery and Reinvestment Act of 2009.

## **COMMUNITY OUTREACH AND PROVIDER-BASED MARKETING ACTIVITIES**

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

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

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

**Providers may not:**

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

The use of the Humana Comprehensive Plan name requires written notice prior to use in television, radio, posters, flyers and print advertisement.

**PROVIDER RESPONSIBILITIES**

The provider must adhere to the following responsibilities:

- Provide all services in a culturally competent manner, accommodate those with disabilities and do not discriminate against anyone based on his or her health status.
- Treat all members with respect and dignity; provide them with appropriate privacy and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release.
- Maintain a safe environment and comply with city, state and federal regulations concerning safety and public hygiene.

- Ensure accessibility and availability of services to members.
- Participate and cooperate in quality management, utilization review and continuing education with other similar programs to provide care in a responsible and cost-effective manner.
- Participate in and cooperate with grievance procedures when notified of a member complaint or grievance.
- Comply with all applicable federal and state laws regarding the confidentiality of member records.
- Maintain communication with the appropriate agencies to provide member care.
- Ensure enrollment or registration by state Medicaid program for compliance with data submission.
- Maintain an emergency response plan.
- In the event of a disaster, the provider shall activate their emergency response plan and participate with Humana Comprehensive Plan to ensure member safety as well as coordinate member care as appropriate.
- Providers contracted with the Humana Comprehensive Plan should refer to their contracts for complete information regarding providers' responsibilities and obligations. Failure to comply could result in contract termination.

## **PROVIDER COMPLAINT SYSTEM**

For all inquiries, including complaints, please contact Humana customer service at **1-888-998-7735** or your provider contracting representative. Based on the type of issue or complaint, your inquiry will be reviewed by a Humana associate with the designated authority to resolve your issue or complaint.

A provider complaint may be filed using the following steps:

### **Verbal Complaint**

A customer service specialist (CSS) will receive the initial call and attempt to resolve any issues or concerns at the time of the call. If the provider requests to file a complaint, the CSS will log the details in the database immediately, document the verbal acknowledgement given to the provider and transfer the complaint to the provider complaint resolution team.

Upon receipt of a complaint not involving claims from the CSS, the provider complaint resolution team will thoroughly investigate each complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the plan's written policies and procedures. The provider complaint resolution team will contact the provider and/or provider's office to research and resolve the issue within 90 days of receipt. Every 15 days, a written status report will be sent to the provider until the issue is resolved. A written notice of the disposition and the basis of the resolution will be sent to the provider within three business days of resolution.

### **Written Complaint**

The provider will submit in writing to:

Humana Long-term Care Plan  
ATTN: Provider Contracting – Provider Complaint

777 Yamato Road, Suite 510  
Boca Raton, FL 33487

Electronic requests may be sent to:

[ltcproviderrelations@humana.com](mailto:ltcproviderrelations@humana.com)

Upon receipt of a complaint not involving claims from the Humana Provider Correspondence team, the provider complaint resolution team will thoroughly investigate each complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the plan's written policies and procedures. The provider complaint resolution team will contact the provider and/or provider's office to research and resolve the issue within 90 days of receipt. Every 15 days, a written status report will be sent to the provider until the issue is resolved. A written notice of the disposition and the basis of the resolution will be sent to the provider within three business days of resolution.

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

For provider complaints related to claims, the provider should follow the same process outlined above. Please note the time frames for filing a claims complaint or reconsideration are listed in the table below.

## CLAIMS COMPLAINT

Topic	Response
In what manner may the claims complaint be submitted?	In writing to: Humana Long-term Care Plan ATTN: Provider Contracting – Provider Complaint 777 Yamato Road, Suite 510 Boca Raton, FL 33487 Electronic requests may be sent to: <a href="mailto:ltcproviderrelations@humana.com">ltcproviderrelations@humana.com</a> Or call 1-888-998-7735
What is the time frame for a provider to submit a claims complaint/reconsideration?	Participating providers: 18 months Nonparticipating physician: 12 months Nonparticipating facility: 30 months
Is an acknowledgement of the claims complaint required?	Yes. Every 15 days, a written status update will be sent to the provider until the issue is resolved.
What is the resolution time frame?	Within 60 days after the receipt of the provider's request for review or appeal, unless claim is under active review by a mediator, arbitrator, or third-party dispute entity.

Topic	Response
What is the time frame for a provider to submit a claim for overpayment?	<p>Provider shall report to Humana when it has received an overpayment within 60 days after the date on which the overpayment was identified, and must notify Humana in writing of the reason for the overpayment as required by 42 CFR 438.608(d)(2), to be mailed to:</p> <p>Humana Healthcare Plans P.O. Box 931655 Atlanta, GA 3331193-1655</p>

## CULTURAL COMPETENCY

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

Participating providers also must meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.

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

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

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

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



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

## FRAUD AND ABUSE POLICY

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

Physician understands and agrees to educate physician's employees about the False Claims Act's prohibition on submitting false or fraudulent claims for payment, penalties for false claims and statements, whistleblower protections and each person's responsibility to prevent and detect fraud, waste and abuse.

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

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

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

Providers may also contact Humana at **1-888-998-7735** and AHCA at **1-888-419-3456, option 5**.

In addition, providers may use the following contacts:

### Telephonic:

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

Email: [siureferrals@humana.com](mailto:siureferrals@humana.com) or [ethics@humana.com](mailto:ethics@humana.com)

Web: [Ethicshelpline.com](https://www.ethicshelpline.com)

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## CLAIMS/BILLING PROTOCOL AND STANDARDS

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Humana maintains and complies with HIPAA standards for the submission and adjudication of claims. This section will provide information regarding the submission and payment process. If you have questions or would like training regarding submitting claims, please contact your local provider contracting representative.

### CLAIM SUBMISSION

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

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

### ELECTRONIC CLAIMS

Humana Comprehensive Plan is capable of receiving electronic claims submission. The acceptable formats include X12 5010 837 institutional, professional and dental formats. Humana Comprehensive Plan also allows for direct data entry (DDE) through [www.availity.com](https://www.availity.com).

When filing an electronic claim, you will need to utilize the following payer ID: 61115 for long-term care claims.

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

- Email: [LTCproviderrelations@humana.com](mailto:LTCproviderrelations@humana.com)
- Phone: 1-888-998-7735
- Web: [www.Availity.com](http://www.Availity.com)

## PAPER CLAIMS

Paper claims should be submitted to the address listed on the back of the member's ID card or to the address listed below:

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

## ENCOUNTER DATA

For claim payment inquiries, complaints, or if there is a factual disagreement with a response, please contact Humana customer service at **1-888-998-7735** or your provider contracting representative. You also may email questions to: [ltpcproviderrelations@humana.com](mailto:ltpcproviderrelations@humana.com)

Submit claim disputes to:

Humana Long-term Care Plan  
ATTN: Provider Contracting – Provider Complaint  
777 Yamato Road, Suite 510  
Boca Raton, FL 33487

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

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

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

Availity®	<a href="http://www.availity.com">www.availity.com</a>	1-800-282-4548
ZirMed®	<a href="http://www.zirmed.com">www.zirmed.com</a>	1-877-494-7633
Trizetto	<a href="http://www.trizetto.com">www.trizetto.com</a>	1-800-556-2231
McKesson	<a href="http://www.mckesson.com">www.mckesson.com</a>	1-800-782-1334
CaparioP <sup>SM</sup>	<a href="http://www.capario.com">www.capario.com</a>	1-800-792-5256
SSI Group	<a href="http://www.thessigroup.com">www.thessigroup.com</a>	1-800-881-2739

AHCA requires 100 percent encounter submissions:

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

Encounters and claims identify members who have received services:

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

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

Payments due as a result of covered services rendered to Medicaid members shall be made by Humana on or before 90 calendar days, or such lesser time as may be contracted for between the parties, after all properly documented invoices and/or claims, and any documentation necessary for Humana to process such claims, have been received by Humana and in accordance with the reimbursement terms and conditions of the agreement and payment rates identified in Exhibit A, which is attached hereto and incorporated by reference.

Claims payments by Humana to provider shall be accompanied by an itemized accounting of the individual claims in the payment including, but not limited to, the member's name, the date of service, the procedure code, service units, the amount of reimbursement and identification of Humana.

Humana shall make no payment, directly or indirectly, to a physician as an inducement to reduce or limit medically necessary services to a member. If Humana operates a physician incentive plan, it shall not provide incentives, monetary or otherwise, for the withholding of medically necessary care.

Humana shall assume full responsibility for collections in the event of third-party liability.

## **COMMON SUBMISSION ERRORS AND HOW TO AVOID THEM**

Common rejection or denial reasons:

1. Patient not found
2. Insured subscriber not found
3. Patient birthdate on the claim does not match that found in our database
4. Missing or wrong information
  - a. Providers submitting with incorrect NPI/ZIP code/taxonomy
  - b. Missing NPI/ZIP code/taxonomy
  - c. Providers submitting encounters with zero-dollar value
5. Invalid HCPCS code submitted
6. No authorization or referral found

How to avoid these errors:

1. Confirm that patient information received and submitted is accurate and correct.
2. Ensure that all required claim form fields are complete and accurate.
3. Obtain proper authorizations and/or referrals for services rendered.
4. Confirm provider information (information registered with AHCA).
5. Ensure billed amounts are not zero dollar. Must submit billed charges.

## **TIMELY FILING**

Providers are required to file timely claims/encounters for all services rendered to Medicaid members.

Providers shall submit to Humana all claims, and if capitated shall submit encounter data, for services rendered to comprehensive plan members in accordance with the terms and conditions in the AHCA contract. Notwithstanding anything to the contrary in the agreement, provider or subcontractor agrees to submit such claims within 180 days from the date of service, or encounter data, as applicable, to Humana within 30 days from the date of service.

The encounter data submission standards required to support encounter data collection and submission are defined by the agency in the Medicaid companion guides, pharmacy payer specifications and this section. In addition, the agency will post encounter data reporting requirements on the following websites:

- [http://portal.flmmis.com/FLPublic/Provider EDI/Provider EDI CompanionGuides/tabId/62/Default.aspx](http://portal.flmmis.com/FLPublic/Provider%20EDI/Provider%20EDI%20CompanionGuides/tabId/62/Default.aspx)

## **CLAIMS OVERPAYMENTS**

Provider shall report to Humana when all claim overpayments for services rendered to Comprehensive Managed Care Plan Members in accordance with the terms and condition in the AHCA Contract that have been received. Notwithstanding anything to the contrary in the agreement, Provider or Subcontractor agree to submit such claims within sixty (60) days after the date on which the overpayment was identified, and to notify Humana in writing the reason for the overpayment as required by 42 CFR 438.608(d)(2). To be mailed to:

Humana Healthcare Plans  
P.O. Box 931655  
Atlanta, GA 3331193-1655

## **PAYMENT SUSPENSION**

Humana shall pay nursing facility providers in compliance with 42 CFR 488.417, and enforce any denial of payment for new admissions (DPNA) issued by the Centers for Medicare & Medicaid Services.

## ERAS AND EFTS

Providers may register to receive their Humana electronic remittance advice (ERA) and payments/electronic funds transfer (EFT) and get paid up to seven days faster. If providers enroll on Availity.com and elect EFT, electronic funds will be utilized.

- Providers can sign up for EFT via [www.availity.com/](http://www.availity.com/).
- Email questions to: [lhcpviderrelations@humana.com](mailto:lhcpviderrelations@humana.com).

## CROSSOVER CLAIMS

Effective Oct. 1, 2016, providers no longer need to send Medicare crossover claims for dually eligible recipients directly to Humana. Under this initiative, providers only need to submit their claims once to the Centers for Medicare & Medicaid Services (CMS) for processing and are no longer required to submit secondary claims to Humana. This means CMS will automatically forward claims for members who are dually eligible for both Medicare and Medicaid coverage. Please note: If a provider submits a claim for a dually eligible member that CMS has already forwarded to Humana, Humana will deny the provider-submitted claim as a duplicate claim.

## INCENTIVE PLANS

Upon request, the physician agrees to disclose to Humana within a reasonable time frame not to exceed 30 days, or such lesser period of time required for Humana to comply with all applicable state and federal laws, rules and regulations, from such request, all of the terms and conditions of any payment arrangement that constitutes a physician incentive plan as defined by CMS and/or any state or federal law, between physician and other physicians. Such disclosure shall be in the form of a certification, or other form as required by CMS and/or AHCA, by the physician and shall contain information necessary for Humana to comply with applicable state and federal laws, rules and regulations and as requested by Humana.

Within 35 days of a request by AHCA or DHHS, physician shall disclose physician's ownership; any significant business transactions between physician and any wholly owned supplier or subcontractor during the five year period ending on the date of the request; and the identity of any owner, agent or managing employee of the physician who has been convicted of a crime relating to any program under Medicare, Medicaid or the Title XX services program.

## ASSISTED LIVING FACILITY PROVIDERS

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

$$\text{Contracted ALF rate} - \text{room and board rate} - \text{patient responsibility} = \text{Humana payment}$$

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

**The provider is required to notify Humana Comprehensive Plan within 24 hours of a member hospitalization or leave of absence from the community.**

**Bed-hold payments** — Humana Comprehensive Plan provides services for bed hold when our member is not in your community. Refer to the member handbook for additional coverage information. Coverage exceptions include:

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

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

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

## **SKILLED NURSING FACILITY (SNF) PROVIDERS**

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

**Custodial care payments** — The facility will be reimbursed by Humana Comprehensive Plan at the current Medicaid per-diem rate established with the state minus patient responsibility determined by the DCF.

**Bed holds for skilled nursing facilities** — Humana Comprehensive Plan pays to reserve a bed for a maximum number of days for each hospital stay. One day is defined as an overnight stay away from the nursing facility. Refer to the member handbook for additional coverage information.

**Bed holds for therapeutic beds** — Humana Comprehensive Plan pays the skilled nursing facility to reserve a residence bed for a resident to go to a family-type setting for a maximum number of days per each state fiscal year. One day is defined as an overnight stay away from the skilled nursing facility. Refer to the member handbook for additional coverage information.

**Bed holds for custodial care members** — Humana Comprehensive Plan follows the same guidelines as Medicaid. If your facility is requesting payment for a bed hold on a Humana Comprehensive Plan member, please submit a copy of your census along with your claim for the time frame in question.

## **HOME HEALTH PROVIDERS**

It is recommended that services are not billed in a date range format. Each service should be listed separately by date of service.

## **PAYMENTS AND BALANCE BILLING**

Payments made by or processed through Humana Comprehensive Plan are in accordance with the terms of your agreement with Humana Long-term Care Plan. Providers may not balance bill members of Humana Comprehensive Plan for covered, authorized services as per your agreement with Humana Long-term Care Plan.

## **CLAIM INQUIRY**

Providers are encouraged to contact the customer service department to inquire about the status of a claim, status of reconsideration or explanation of a denial. A customer service representative can be reached by calling **1-888-998-7735**. Hours of operation are 8 a.m. to 8 p.m., Monday through Friday. If you are calling after hours, please leave a message and a representative will return your call within one business day.

## **CLAIM DENIALS**

All denials include an explanation of denial and/or explanation of adjustment when applicable. Denial codes are subject to change and/or additional codes may be utilized. Please contact the claims customer service department at **1-888-998-7735** with questions or concerns regarding a denial or partial denial of payment.

## **FORMAL GRIEVANCES/APPEALS**

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

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

## **FILING A FORMAL GRIEVANCE OR AN APPEAL**

If an enrollee has questions or an issue, he or she may call Humana Customer Service at **1-888-998-7732** between 8 a.m. and 8 p.m.



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

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

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

The enrollee has the right to continue services during the grievance/appeal process. If the enrollee would like his/her services to continue, the enrollee must submit an appeal within 10 business days after the notice of action is mailed; or within 10 business days after the intended effective date of action, whichever is later. However, if the decision of the Grievance/Appeal Committee is not in the enrollee's favor, the enrollee may have to pay for those services.

**The grievance/appeal must have the following:**

- Name, address, telephone number and ID number
- Facts and details of what actions were taken to correct the issue
- What action would resolve the grievance/appeal
- Signature
- Date

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

**Florida Medicaid Grievance First-level Review**

Topic	Response
In what manner may the grievance be submitted?	Oral or written
What is the time frame to submit the grievance?	Unlimited
Is an Appointment of Representation (AOR) required?	Yes
Is an Acknowledgment of the Grievance required?	Yes, within five business day of receipt
What is the resolution time	No later than 90 calendar days of receipt

Topic	Response
frame?	

**Appeal:** An enrollee must file the appeal either verbally or in writing within 60 calendar days of the receipt of the notice of action, and except when expedited resolution is required, must be followed with a written notice within 10 calendar days of the oral filing. The date of the oral notice will be considered the date of receipt. An enrollee has up to one year to file an appeal if the denial is not in writing. Humana will resolve the appeal as quickly as the health condition requires. A letter telling the enrollee the outcome of the appeal will go out within 45 days from the date Humana receives the request. The enrollee can request a 14-day extension if needed. We also can request an extension if additional information is needed and is in the enrollee's best interest. Humana will inform the enrollee by mail of any extra time needed to make a decision, what additional information is needed and why it is in the enrollee's best interest.

### Florida Medicaid Appeal First-level Review

#### Determination

Topic	Response
In what manner may the appeal be submitted?	Oral (must be followed by written request within 10 calendar days from the oral filing) or written  If the request is submitted orally, the date the oral appeal is made is considered the date of receipt.
What is the time frame to submit the appeal?	Within 60 days from the date of the notice of adverse action
Is an Appointment of Representation (AOR) required?	Yes
Is an Acknowledgment of the Appeal required?	Yes, within five business days of the appeal receipt
What is the decision notification method?	Written
What is the decision time frame?	Appeal determinations should be rendered as expeditiously as the member's health condition requires but no later than 30 calendar days from receipt, whether received orally or in writing.

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

**Humana** shall not discriminate against a **provider** or take punitive action against a **provider** who requests an expedited resolution or supports an member's appeal as required by 42 CFR 438.410(b).

#### Florida Medicaid Expedited Appeal First-level Review

Topic	Response
In what manner may the appeal be submitted?	Oral or written
What is the time frame to submit the appeal?	Within 60 calendar days from the date of the notice of action
Is an Appointment of Representation (AOR) required?	Yes, except from the provider
Is an Acknowledgment of the Appeal required?	Yes, oral acknowledgment is required no later than 24 hours of receipt
What is the decision time frame?	As expeditiously as the member's health condition requires but not to exceed 72 hours after receipt, whether the request was submitted orally or in writing

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

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

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

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

They are as follows:

Agency for Healthcare Administration  
Medicaid Hearing Unit  
P.O. Box 60127  
Ft. Myers, FL 33906

Toll free: 1-877-254-1055

Fax: 1-239-338-2642

Email: [MedicaidHearingUnit@ahca.myflorida.com](mailto:MedicaidHearingUnit@ahca.myflorida.com)

[Appeal\\_Hearings@dcf.state.fl.us](mailto:Appeal_Hearings@dcf.state.fl.us)

Website: [www.myflfamilies.com/about-us/office-inspector-general/investigation-reports/appeal-hearings](http://www.myflfamilies.com/about-us/office-inspector-general/investigation-reports/appeal-hearings)

The enrollee has the right to continue to receive benefits during a Medicaid Fair Hearing. He or she can request to continue to receive benefits by calling our customer service department at **1-800-477-6931**

between 8 a.m. and 8 p.m., Monday through Friday. If the decision is not in the enrollee's favor, he or she may have to pay for those benefits. The enrollee has the right to review his or her case before and during the appeal process.

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

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

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

Humana Long-term Care Plan  
Attn: Grievance/Appeal Department  
P.O. Box 14546  
Lexington, KY 40512-4546

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

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

Humana Long-term Care Plan  
777 Yamato Road, Suite 510  
Boca Raton, FL 33487

Office hours are 9 a.m. to 5 p.m. Eastern time, Monday through Friday.

If the enrollee wishes to contact our customer service department by phone, he or she may call 1-888-998-7732.

If the enrollee cannot hear or has trouble talking, he or she may call 711. Customer service department hours are 8 a.m. to 8 p.m. Eastern time, Monday through Friday.

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

## SECTION III – HUMANA COMPREHENSIVE PLAN

### INTRODUCTION

If you have a patient/member who is enrolled in both Humana's MMA plan and LTC plan, the plan name will be **Humana Comprehensive**.

Please refer to Section I – Humana Medical Plan for providers who are rendering medical services.

Please refer to Section II – Humana Long-term Care for providers who are rendering long-term-care services.

#### HUMANA COMPREHENSIVE PLAN ID SAMPLES

**Humana.**  
**Humana Comprehensive Plan**

**MEMBER NAME**  
**Member ID: HXXXXXXXXX**

Medicaid ID#: XXXXXXXX      Group #: XXXXXXXX  
 Date of Birth: XX/XX/XX      RxBIN: 610649  
 Effective Date: XX/XX/XX      RxPCN: 03190000

PCP Name: XXXXXXXXX  
 PCP Phone: (XXX) XXX-XXXX  
 Primary Care Address: XXXXXXXXXXXX

**Member/Provider Service: 1-800-477-6931**

Pharmacist Rx Inquiries: 1-800-865-8715  
 Pre-Certification and/or admission notification call: 1-800-523-0023

Please mail all claims to:

<b>Managed Medical Assistance</b>	<b>Long Term Care</b>
Humana Medical	Humana Long Term Care
P.O. Box 14601	P.O. Box 14732
Lexington, KY 40512-4601	Lexington, KY 40512-4732

#### Spanish ID

**Humana.**  
**Humana Comprehensive Plan**

**MEMBER NAME**  
**Id. del afiliado: HXXXXXXXXX**

Id. de Medicaid: XXXXXXXX      N.º de grupo: XXXXXXXX  
 Fecha de nacimiento: XX/XX/XX      RxBIN: 610649  
 Fecha de entrada en vigor: XX/XX/XX      RxPCN: 03190000

Nombre del PCP: XXXXXXXXX  
 No. de teléfono del PCP: (XXX) XXX-XXXX  
 Dirección de atención primaria: XXXXXXXXXXXX

**Servicio para afiliados/proveedores: 1-800-477-6931**

Consultas sobre recetas de farmacéuticos: 1-800-865-8715  
 Precertificación y/o notificación de admisión llamar al: 1-800-523-0023

Por favor, envíe todas las reclamaciones por correo a:

<b>Managed Medical Assistance</b>	<b>Long Term Care</b>
Humana Medical	Humana Long Term Care
P.O. Box 14601	P.O. Box 14732
Lexington, KY 40512-4601	Lexington, KY 40512-4732