

Provider Manual

For physicians, hospitals and healthcare providers



Humana®

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I. Overview of Humana and ChoiceCare

Humana: Humana Inc., headquartered in Louisville, Kentucky, is one of the nation's largest publicly traded full service health, well-being solutions and supplemental benefits companies. Humana Inc.'s affiliated health plans (Humana) offer a wide array of health insurance and well-being products and related services through traditional and consumer-choice health plans (plans) to employer groups, government-sponsored plans and individuals, as well as primary and workplace care through its medical centers and worksite medical facilities. Over its more than 50 year history, Humana has consistently seized opportunities to meet changing customer needs. Today, the company is a leader in consumer engagement and providing guidance designed to lead to a better plan experience throughout its diversified customer portfolio.

ChoiceCare® Network: Health Value Management Inc., d/b/a ChoiceCare Network (ChoiceCare), is a wholly owned subsidiary of Humana Inc. ChoiceCare is Humana Inc.'s national PPO rental network and includes more than 500,000 providers and 2,700 hospitals across all 50 states and the District of Columbia. Provider participation agreements (agreements) are written with physicians, hospitals and healthcare providers for all states. The ChoiceCare Network serves small and large group PPO and self-insured employers, insurance companies, governmental agencies, third-party administrators and other similar entities as customers.

Note: Humana contracts with numerous other providers for participation in Humana's provider networks that are not part of the ChoiceCare Network.

Please note that ChoiceCare is not an insurance company, health plan administrator or other payer and is solely a rental network as described above.

Purpose of this manual: Humana's Provider Manual for Physicians, Hospitals and Other Healthcare Providers (manual) is an extension of the agreement between Humana and/or ChoiceCare and all provider types including, but not limited to, physicians, hospitals and ancillary healthcare providers (hereinafter collectively and/or individually, as the context requires, referred to as "provider(s)"). This manual shall apply equally to both Humana and ChoiceCare participating providers. If only the term "Humana" is used in a given provision of this manual, that shall also mean "ChoiceCare," unless the context of the provision requires otherwise.

This manual furnishes all such participating providers and their office staff with important information concerning Humana and ChoiceCare policies and procedures, claims submission and adjudication requirements and guidelines used to administer Humana health plans. Other policies and procedures are posted online. State-specific Medicaid provider manuals (sometimes referred to as appendices) are also available and may contain additional information. This manual replaces and supersedes any and all other previous versions and is located on Humana.com, with accessibility through Availity.com and ChoiceCare.com. A paper copy may be obtained at any time upon written request to Humana. Any capitalized terms not otherwise defined herein shall have the meaning as set forth in the agreement.

Except as may otherwise be set forth in the agreement, providers are contractually required to comply with all provisions contained in this manual. However, in the event of a conflict between the obligations, terms, conditions of the participation agreement and this manual, the obligations, terms and conditions in the agreement shall control.

Revisions to this manual constitute revisions to Humana's policies and procedures.

Variations in applicable laws, regulations and governmental agency guidance including, but not limited to, state or federal laws, regulations and/or changes to such laws, regulations or guidance may create certain requirements related to the content in this manual that are not expressly set forth in this manual. Any requirements under applicable law, regulation or guidance that are not expressly set forth in the content of this manual shall be incorporated herein by this reference and shall apply to providers and/or Humana where applicable. Such laws and regulations, if more stringent, take precedence over the content in this manual. Providers are responsible for complying with all laws and regulations that are applicable.

Note: State laws and/or regulations do not affect the adjudication of claims for Medicare Advantage members.

Humana may deny payment for any services or supplies for which a provider failed to comply with Humana's policies and procedures.

Responsibility for Provision of Medical Services: Providers are independent contractors and are solely responsible to members for the provision of health services and the quality of those services. This means providers and Humana do not have an employer-employee, principal-agent, partnership, joint venture or similar arrangement. It also means that providers have a duty to exercise independent medical judgment to make independent healthcare treatment decisions, regardless of whether a health service is determined to be a covered service. Nothing in the agreement or this manual is intended to create any right for Humana to intervene in the provider's medical decision-making regarding a member. Additionally, providers are responsible for the costs, damages, claims and liabilities that arise out of their own actions. Humana does not endorse or control the clinical judgment or treatment recommendations made by providers.

Humana requires preauthorization with respect to certain services and procedures. Humana's preauthorization determination relates solely to administering its plans and is not, nor should it be construed to be, a medical decision. The provider, along with the member, makes the decision whether the services or procedures are provided.

Medical Directors: Medical directors serve as the major interface between healthcare organizations and participating providers and other healthcare providers in the community. The medical director is not engaged in the practice of medicine while acting in the medical director role. The role is invaluable in establishing a provider network as well as facilitating provider participation and cooperation. The medical director's responsibilities include, but are not limited to, the oversight of:

- Quality management programs required by federal or state law or accrediting agencies
- Humana health programs
- Credentialing
- Utilization management (UM)/health services

Humana Plans: Humana offers a variety of health plans through its insurance subsidiaries; however, not all plans are available in all markets. Contact the Provider Relations team at 1-800-626-2741 for more information.

QUESTIONS OR COMMENTS: Questions or comments about this manual should be directed to the provider representative in the local Humana market office. Any suggestions regarding this manual or its contents should be directed to:

Humana
National Network Operations – HUM 07
500 W. Main Street
Louisville, KY 40202

II. Contact Information

Online Provider Portals

Network providers may visit Humana.com/providers and Availity.com and log into the Availity Provider Portal for administrative and informational needs pertaining to Humana. The unsecured section of Humana's site offers a variety of information resources, including Humana's drug list and links to clinical practice guidelines. The Availity Provider Portal (registration required) features transactional capabilities, such as member eligibility verification, claims status, preauthorization requests, referral submissions, medical records management and fee-schedule information.

Humana.com/providers (no registration is required):

- **Clinical and Healthcare Resources:** Quickly locate details about Humana's [clinical practice guidelines](#), patient

health education, clinical services and innovation, transplant services, bariatric services and disease management programs.

- **Continuing Medical Education (CME) Opportunities:** Find online opportunities to learn the latest information and recommendations regarding healthcare best practices.
- **Provider Medicare Information:** Provides more information about plans offered in specific areas.
- **Preauthorization List:** Provides a comprehensive list of services and medications outlining which services and plans require preauthorization or notification.
- **Provider Appeal Process:** Provides an explanation of the [appeals process](#) for physicians and other healthcare providers.
- **Credentialing Services:** Council for Affordable Quality Healthcare (CAQH) – Provides a link to CAQH’s Universal Credentialing Data source.
- **Provider Web-based Tutorials and Educational Materials:** Get the most out of Humana’s web tools by attending a provider webinar session. The “[Making It Easier](#)” series includes narrated video presentations that address a variety of claims policy and process questions, as well as other topics of interest to providers of all types.
- **Provider Onboarding and Support Materials:** [Educational tools](#) that are available on demand
- **Resources for Humana-insured Patients:** Learn more about services that may benefit patients with Humana plans.
- **Prescription Tools and Resources:** Learn more about Humana’s pharmacy programs by using the drug list search, prescription tools and resources and pharmacy locator.
- **Claims Processing Edit Updates:** Access summaries of changes planned for our claims payment systems at [Humana.com/Edits](#).
- **Claims Payment Policies:** Learn about acceptable billing practices and reimbursement at [Humana.com/ClaimPaymentPolicies](#).
- **Provider Newsletters:** Quarterly communications that contain important updates and information for network providers. Follow the link to [Humana’s YourPractice](#).

Availity Provider Portal (registration required):

The multi-payer Availity Provider Portal offers online tools to help healthcare professionals, including third- party administrators, to streamline administrative tasks. After registration has been completed, the following may be accessed:

- Eligibility and benefits inquiry (includes out-of-pocket accumulators)
- Certificate of coverage access
- Referral/authorization submission, modification and inquiry
- Claims status inquiry
- Remittance advice inquiry and download
- Fee schedule inquiry
- Online electronic claims submission
- Electronic funds transfer registration
- Service fund view and download
- Provider directory

- Code-editing simulator
- Medical records management and medical attachments

Contact Us

Case Management:

Refer to the Population Health Management section for more detailed information.

Fraud, Waste and Abuse:

Humana Hotline: 1-800-614-4126.

HumanaAccess Card:

1-800-604-6228 (Humana's Spending Account Administration team)

Humana Customer Service:

Call 1-800-4HUMANA (1-800-448-6262) or call the number listed on the back of the member's ID card. Contact Humana Customer Service for assistance with questions regarding:

- Benefits
- Claims
- Copayments
- Eligibility
- Grievances and/or appeals
- Provider directory concerns

Member Eligibility Inquiries:

- Visit the Availity Provider Portal at [Availity.com](https://www.availity.com) or
- Telephone: Commercial members call 1-800-4HUMANA (1-800-448-6262), or Medicare Advantage/Medicaid members call 1-800-457-4708. Florida Medicaid members call 1-800-477-6931.

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

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

Preauthorization:

- Access the Availity Provider Portal at [Availity.com](https://www.availity.com) where you can complete the preauthorization process for many services online or
- Telephone 1-800-523-0023

Provider Relations:

Telephone 1-800-626-2741; 8 a.m. to 5 p.m. Central time.

ChoiceCare Network

Provider Relations Department

Telephone Number: 1-800-626-2741

Referrals:

Telephone: 1-800-523-0023. Referrals also may be submitted electronically via the Availity Provider Portal at [Availity.com](https://www.availity.com).

III. Claims Procedures

Checking Member Eligibility

To check eligibility via the web: If provider is registered for the Availity Provider Portal, a specific member's eligibility can be checked online by entering the subscriber's identification (ID) number and date of birth.

If a provider is not yet registered on the Availity Provider Portal, go to www.availity.com to register. Follow the prompts to complete the online registration process.

To check eligibility via the phone:

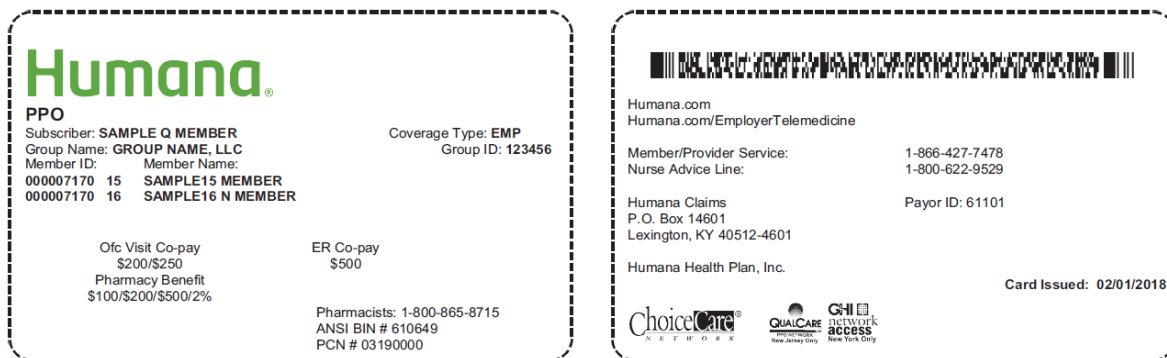
- Call Humana Customer Service at 1-800-4HUMANA or the number listed on the back of the member's ID card.
- Provide the subscriber's identification number and other authentication information

ChoiceCare is a provider network, not an insurance company, health plan administrator or other payer and, therefore, does not provide verification of member eligibility and benefits. The member ID card bears the name and logo of the insurance company or plan administrator to contact to verify member benefits and eligibility. The verification phone number and/or Website address also can be found on the member ID card.

Member Identification (ID) Card

The member identification (ID) card is issued to members upon enrollment and contains information regarding benefit coverage, copayments and telephone numbers for questions regarding those benefits. Members have been issued unique member identification (UMID) numbers that are assigned by Humana. For some plans, the UMID is comprised of one alpha character and eight digits followed by a two-digit dependent code, such as H12345678-02. Other plans will have a nine-digit all numeric ID number. The reason for the change is to protect a member's privacy in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations. Key information is identified on the sample identification card below.

Note: To avoid potential problems with identity theft or fraud, ask the member for a separate form of identification, such as his/her driver's license, along with the member ID card.



When applicable, a copayment is collected from the member at the time of service. Copayments for office visits and prescriptions are listed on the member's ID card. Since copayments are subject to change, it is recommended that copayment amounts be verified via the Availity Provider Portal, or by calling the number listed on the back of the member's ID card.

Providers should have a timely process in place to refund members any difference between their copayment and the allowable amount for the office visit (in instances when the allowed amount is less than the copay collected) when the claim is processed by Humana. For assistance with questions, please contact Humana Customer Service at the number listed on the back of the member's ID card.

HumanaAccess Card

HumanaAccess cards are issued to members with Health Savings Accounts (HSA), Personal Care Accounts (PCA) or Flexible Spending Accounts (FSA). The HumanaAccess card may be used at physician offices, medical labs, hospitals and for other eligible medical expenses.

The HumanaAccess card is for members with Humana HSA, PCA or FSA plans. This is not a medical ID card. This card enables the member to access HSA, PCA or FSA funds. Members will have separate medical insurance ID cards.

Below is a sample of the HumanaAccess card:



Please note the following:

- If it is necessary to make a copy of the HumanaAccess card, mark out the account number on the copy after use to prevent fraud.
- The member must have funds available to cover charges to the card.
- The card will be declined if there are insufficient funds.
- Only the subscriber's name appears on the HumanaAccess card.

To process payments for qualified medical expenses with the HumanaAccess Card:

The member may present the HumanaAccess card at the time of service or use it as a form of payment after he/she receives the bill. If there is no copayment, as with a Humana plan with a PCA, "N/A" will be reflected under the copayment line. To process the card for a payment:

- Swipe the member's card through the credit/debit card machine.
- Even though the card is a debit card, select "credit," if prompted. (No personal identification number [PIN] is required.) The payment is automatically deducted from the member's appropriate HSA, PCA or FSA.
- Provide a receipt to the member and payment will be received with other payments.

Two distinct ways to use the HumanaAccess card:

There are two ways the card should be charged for medical expenses. Humana is aware that some offices, as policy, charge a portion of the service at the time of the visit in place of a copayment, when a copayment does not apply to the service. The best and most appropriate use of the HumanaAccess card for medical expenses is defined below:

- 1. Copayments at time of visit:** Swipe the member's card upfront at the time of visit for copayments only. (**Note:** Some plans do not have a copayment.) Press the credit key even though it is a debit card.

- 2. Coinsurance and deductibles after the office visit:** When the remittance process provides the member-owned portion of the claim, key in the number and expiration date. The member's card is automatically charged. (**Note:** Provider needs to have an Easy Pay Consent Form (available on Humana.com in the providers' section) on file, signed by the member, allowing the provider to charge member's payment card for the balance of fees not paid by insurance company.

Humana recommends waiting until the claims adjudication process is complete before portions of the deductible or coinsurance are charged to the card. This is a more hassle-free approach, enabling the correct amount to be charged to the card and eliminating back-end reconciliation issues.

If provider's internal office policy requires a form of upfront payment, charge a small percentage of the expected cost to the card. For fee schedule guidance, member deductibles and coinsurance, log into the Availity Provider Portal. If the amount charged on the card does not match the adjudicated claim amount, the member will need the receipt to reconcile the final charges. The IRS has very stringent reconciliation guidelines and auditing processes for funding accounts such as FSAs and PCAs. In addition, the office will need to issue a timely credit (or debit) to the card for any difference between the charged amount and the actual member responsibility.

Member overpayments and credits to HumanaAccess cards:

There are a variety of situations which may cause a member's HumanaAccess card to be overcharged. When this happens, please credit the member's HumanaAccess card account promptly, as the member's funds may be needed for other medical expenses. Be advised that these funds belong to the member – not Humana. If a Humana member has overpaid with the HumanaAccess card and is due a credit:

- Do not issue a check.
- Credit the amount owed to the Humana member directly back onto the HumanaAccess card by running a credit transaction through provider's terminal.
- Notify the member of any transaction.

To avoid overcharging situations, Humana recommends waiting until the claims adjudication process is complete before portions of the deductible or coinsurance are charged to the card. For assistance with problems in processing a member's payment with the HumanaAccess card, call Humana's Spending Account Administration Team at 1-800-604-6228.

Medical Coverage Policies, Clinical Trials

Humana's medical coverage policies are available on Humana.com (Provider section > Resources > Medical/Pharmacy Coverage Policies). See "Utilization Management, Clinical Review Guidelines" for further information about Humana's medical coverage policies. The medical coverage policy specific to clinical trials contains the details on the codes that are to be billed when services are provided as part of a clinical trial. For claims to be paid properly, a provider must include these codes on the claims submission.

Claims Submission and Processing

Claims Submission: Unless applicable law provides that submissions may be in paper format, providers must submit all claims, encounters and clinical data to Humana by electronic means. Those electronic means accepted as industry standard may include claims clearinghouses or electronic data interface companies used by Humana. Providers using electronic submission must submit all claims to Humana or its designee, as applicable, using the HIPAA-compliant 837 electronic format. When the 837 standard electronic format requires the submission of a taxonomy code from one or more providers, a taxonomy code must be submitted for each provider, and the taxonomy code must be the code most appropriate for that provider and the services provided.

Provider acknowledges that Humana may market certain programs and/or products that will require electronic submission of claims and clinical data in order for the provider to participate. Providers must notify Humana when they have completed their transition to electronic medical records and agree to provide information on the status to Humana upon request. Unless applicable law mandates that submission may be in paper format, provider must submit to Humana all Humana required clinical data (including, but not limited to, laboratory data) by available electronic means within 30 days of the date of service or within the time specified by applicable law.

When submission of a paper format is permissible, providers must submit claims using an original CMS-1500 and/or an original UB-04 form, or their successors.

Humana expects that all services resulting in the generation of a lab result require the provider to submit the corresponding lab results data electronically to Humana within 30 days of the member's date of service. The lab results data must be submitted electronically in Humana's standard file layout (<http://apps.humana.com/marketing/documents.asp?file=2098642>), and include the correct Logical Observation Identifiers Names and Codes (LONIC) and other values associated with the result in the correct data format as outlined in Humana's standard file layout. Submission must be made through one of Humana's approved methods as outlined on the Humana provider website. Provider's failure to comply with claims, encounters and lab results data submission guidelines may result in a reduction of the amount, if any, which otherwise would be due under this agreement for the service. A reduction in the capitation payment amount may be applicable to capitated providers.

This data will be used within the guidelines allowed by HIPAA and the Genetic Information Nondiscrimination Act (GINA) and applicable state laws, if any. This data allows Humana to comply with accreditation and regulatory requirements established by CMS, the National Committee for Quality Assurance (NCQA) and/or other regulatory agencies. This data also may be used to establish member clinical profiles, to more easily and quickly predict disease progression and reduce acuity, as well as to calculate Healthcare Effectiveness Data and Information Set (HEDIS) qualitative scores and other member-related initiatives.

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:

Humana Medical Claims	Humana Claims Office P.O. Box 14601 Lexington, KY 40512-4601
Humana Encounters	Humana Claims Office P.O. Box 14605 Lexington, KY 40512-4605

Note: No claim is complete for a covered service and/or no reimbursement is due for a covered service unless provider's performance of that covered service is fully and accurately documented in the member's medical record prior to the initial submission of the claim.

Real-time Adjudication (RTA): This system offers a simplified administrative approach for submitting and processing claims through Availity® LLC. Humana's RTA process enables a provider to bill for service before the member leaves the office and to receive a fully adjudicated response back – at the time of service. With this technology, providers instantly can see the total and allowable charges, as well as the patient liability amount, such as coinsurance, deductible, etc. Therefore, providers can collect accurately at the time of service and not have to collect an estimated amount. Call Humana Customer Service for specific information on the system.

Note: The RTA process may not work for every claim.

Prompt Payment of Claims: A claim is deemed to have been adjudicated promptly if it has been paid, pended for review (when applicable under state guidelines), or denied within the time established by the applicable state or federal prompt payment statutes and/or regulations. To assure that a claim is processed promptly and within a timely manner, the following criteria must be satisfied upon the claim's submission to Humana:

- The claim must be submitted either electronically or by paper if permitted by applicable law.
- The claim must be “complete” and must qualify as a “clean claim.”
 - Complete – the information provided in the claim must be sufficient to substantiate the services rendered to the Humana member.
 - Clean claim – the claim must satisfy the description set forth in state or federal law, as applicable, based upon the type of plan.

- A member's original signature, or a "signature on file" or "assignment on file" stamp is required for payments made directly to the provider.

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

- Separate charges must be itemized on separate lines. Medical record documentation must validate the scope of services provided and billed.
- The time frame for submitting claims is listed below, if not otherwise specified by the agreement or applicable state or federal law:
 - Commercial lines of business: 180 days from date of service for physicians; 90 days from date of service for facilities and ancillary providers
 - Medicare lines of business: one (1) calendar year from date of service

Specialist Providers: For commercial HMO and Medicare Advantage HMO, reimbursement for specialist services is dependent upon referral authorization and corresponding documentation. All specialist claims must include a referral authorization number, when applicable, or an inpatient authorization number. The referral authorization or inpatient authorization number must be shown in Box 23 of the CMS-1500 Claim Form or Box 64 of the UB04 Claim Form or loop 2300/REF02 segment which is the equivalent electronic submission field. For additional information, see the Referrals heading of this manual.

Note: If the referral authorization number is not on the claim, the claim may be rejected. The member may not be balance billed for this type of rejected claim.

Inpatient Specialty Services: Depending on the type of plan, claims for inpatient treatment may require an inpatient authorization number. If the physician is not the admitting physician, the authorization number is obtained from the member's chart, member's primary care office, IPA, delegated entity or Humana Customer Service.

Note: If the inpatient authorization number is not on the claim, the claim may be rejected. The member may not be balance billed for this type of rejected claim.

Requests for Review of Denied Claims: Providers may request a review of claim payment denials by the plan(s). To obtain a review, providers must call Humana Customer Service at the number listed on the back of the member's ID card or send a written request to the appropriate Humana claims address. For additional information, see the Provider Claims Dispute Process section of this manual.

Claims Processing Procedures: Humana will process accurate and complete provider claims in accordance with Humana's normal claims processing procedures, including, but not limited to, claims processing edits and claims payment policies, and applicable state and/or federal laws, rules and regulations. See the providers' section of Humana.com to access a summary of changes to claims processing procedures; this summary of changes to claims processing procedures is not intended to be an exhaustive list.

Such claims processing procedures include review of the interaction of a number of factors. The result of Humana's claims processing procedures will be dependent upon the factors reported on each claim. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures, but examples of the most commonly used factors are:

- The complexity of a service
- Whether a service is one of multiple same-day services such that the cost of the service to the provider is less than if the service had been provided on a different day. For example:
 - Two or more surgeries performed the same day
 - Two or more therapy services performed the same day
- Whether an assistant surgeon, surgical assistant or any other provider who is billing independently is involved

- When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together
- Whether the service is reasonably expected to be provided for the diagnosis reported
- Whether a service was performed specifically for the member
- Whether services can be billed as a complete set of services under one billing code

Humana develops claims processing procedures based on review of one or more of the following sources, including, but not limited to:

- Medicare laws, regulations, manuals and other related guidance
- Federal and state laws, rules and regulations, including instructions published in the Federal Register
- National Uniform Billing Committee (NUBC) guidance including the UB-04 Data Specifications Manual
- American Medical Association's (AMA) Current Procedural Terminology (CPT®) and associated AMA publications and services
- CMS' Healthcare Common Procedure Coding System (HCPCS) and associated CMS publications and services
- International Classification of Diseases (ICD)
- American Hospital Association's (AHA) Coding Clinic Guidelines
- Uniform Billing Editor
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services
- Food and Drug Administration (FDA) guidance
- Medical and surgical specialty societies and associations
- Industry-standard utilization management criteria and/or care guidelines
- Our medical and pharmacy coverage policies
- Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed literature

Changes to any one of the sources may or may not lead Humana to modify current or adopt new claims processing procedures.

These claims processing procedures may result in an adjustment or denial of reimbursement, a request for the submission of relevant medical records, prior to payment, or the financial recovery of a previous reimbursement. Providers may access additional information on Humana's website at www.humana.com. An adjustment in reimbursement as a result of claims processing procedures is not an indication that the service provided is a non-covered service.

Providers may submit a dispute request of any adjustment produced by these claims processing procedures by submitting a timely request to Humana. For additional information, see the Provider Claims Dispute Process section of this manual.

Pass-through Billing: Humana prohibits pass-through billing. Pass-through billing occurs when a provider bills for a service for which neither that provider nor any individual under that provider's direct employment performed that service. Provider agrees that pass-through billing services will not be eligible for reimbursement from Humana and provider shall not bill, charge, seek payment or have any recourse against Humana or members for any amounts related to the pass-through billing provision.

Reimbursement

Payment terms are defined in the agreement. Additionally, the amount of payment for services provided may be affected by one or more of the following factors including, but not limited to:

- Member's eligibility at the time of service
- Whether services provided are covered by the member's plan
- Whether services provided are medically necessary, as required by the member's plan
- Whether services provided require prior approval by the member's plan
- Amount of the provider's billed charges
- Member copayments, coinsurance, deductibles and other cost-share amounts due from the member
- Coordination of benefits with third-party payers as applicable
- Adjustments of payments based on claims processing procedures described in the "Claims Processing Procedures" subheading in this manual
- Adjustments of payments based on provider payment integrity policies which can be found at Humana.com, providers' section

Humana applies site-of-service payment differentials, based on the place of service, to the reimbursement of physician or other healthcare professional services. Additionally, Humana does not reimburse a physician or other healthcare professional for the technical component of a service provided to a member registered as an inpatient or outpatient at a hospital or other facility.

A provider who receives reimbursement for services rendered to a Humana Medicare Advantage member must comply with all federal laws, rules and regulations applicable to individuals and entities receiving federal funds, including without limitation Title VI of the Civil Rights Act of 1964, Rehabilitation Act of 1973, Age Discrimination Act of 1975 and the Americans with Disabilities Act of 1990.

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

Note: Additional information may justify additional payment for some claims submitted by physicians and other healthcare professionals. For example, a provider's clinical notes may establish that a procedure initially determined as incidental to another procedure actually involved distinct and significant provider efforts during provider's encounter with the member.

Request for Claims Dispute: If a provider disagrees with how Humana has adjudicated a claim, the provider should follow the procedures set forth in the "Claims Processing Procedures" subheading in the manual regarding provider claims dispute or any applicable state laws.

Balance Billing: Providers must accept as payment in full from Humana payment for covered services provided to health plan members in accordance with the reimbursement terms outlined in the agreement. Members are responsible for applicable copayment, coinsurance and deductible amounts. For covered services, providers may not balance bill members for an amount other than their applicable copayment, coinsurance and/or deductible responsibilities. Subject to the limitation for services provided to a Medicare Advantage plan member, discussed below, a provider is not prohibited by the agreement from collecting from health plan members for a service not covered under the terms of the applicable member plan. A reduction in payment as a result of claims processing procedures is not an indication that the service provided is a non-covered service.

Note: For a Medicare Advantage plan member, a provider may only collect for a service not covered under the terms of the applicable member plan if the provider followed the procedures outlined in the Utilization Management/ Preauthorization (Prior Authorization) section of this manual.

Services Which Are Not Medically Necessary: Provider agrees that, when Humana determines that rendered services

covered under the terms of the applicable member plan were not medically necessary, provider shall not bill, charge, seek payment or have any recourse against member for such services.

Physician or Other Healthcare Professional Surgical Payments: Professional reimbursement for surgical services includes charges for preoperative evaluation and care, surgical procedures and postoperative care. The following claims processing procedures apply to surgical procedures and related services; this is not an all-inclusive list. See the providers' section of Humana.com for a more detailed explanation of [claims payment policies](#) and/or code edit notifications.

- **Assistant at Surgery:** When a physician or non-physician practitioner (NPP) actively assists the primary surgeon, Humana reimburses the assistant at surgery services per the assistant-at-surgery agreement and Humana's claims payment policy. It is the responsibility of the participating primary surgeon to select a participating assistant at surgery.
- **Bilateral Surgery:** When procedures are performed on both sides of the body during the same operative session by the same physician, a bilateral payment adjustment may apply, based on provider's agreement and Humana's claims payment policy.
- **Co-surgeon:** When two or more surgeons perform surgery on the same patient during the same operative session, Humana reimburses the co-surgeon services per each co-surgeon's agreement and Humana's claims payment policy.
- **Complications:** When the work required to provide a service was substantially greater than is typically required, such as for excessive hemorrhaging, the complication should be documented in the operative report. A determination will be made by a clinician on whether the complication merits additional payment.
- **Complications after Surgery:** When there is an unplanned return to the operation room by the same practitioner due to complications after surgery, charges for only the intraoperative portion of the surgery are reimbursed.
- **Decision for Surgery:** No more than one charge for an evaluation and management service at which the initial decision to perform surgery is made will be eligible for payment separate from the surgery.
- **Incidental Surgeries:** A procedure that was performed incidental to the primary surgery will be considered as part of the primary surgery charges and will not be eligible for additional payment. For example, an appendectomy would be incidental when performed during a cholecystectomy.
- **Multiple Surgeries:** When several surgeries are performed by the same practitioner or multiple practitioners within the same group practice with the same specialty, Humana applies a multiple surgery reduction for both commercial and Medicare Advantage products. See provider's agreement and Humana's claims-payment policy for the relevant reductions. This reduction applies when eligible multiple surgical procedures are performed during one continuous surgical session or when multiple surgical procedures are performed on the same day.
- **Preoperative and Postoperative Care:** Charges for preoperative and postoperative care are considered to be included in the global surgical service charge and are not reimbursed separately when preoperative, surgical and postoperative care are provided by the same physician or other healthcare professional.

Overpayments: Humana Provider Payment Integrity

1. Overview

Humana strives to offer our members high-quality healthcare at affordable rates. To facilitate this objective, Humana Provider Payment Integrity (PPI) reviews Humana's claims payments for accuracy and requests refunds if claims are overpaid or paid in error.

2. Contacts, general inquiries and escalation process

For more information on how to resolve recoupment concerns, such as overpayments, financial recovery reviews, disputes and medical record requests, please visit

www.humana.com/provider/support/claims/financial-recovery/” at Humana.com

3. Provider Payment Integrity medical record review process

Humana operates a review program to detect, prevent and correct fraud, waste and abuse and to facilitate accurate claim payment. For more information, please visit <https://www.humana.com/provider/support/claims/medical-record-review> at humana.com.

IV. Utilization Management

Our Utilization Management (UM) Program is designed to ensure members receive access to the right care in the right place and at the right time. Our goal is to optimize the member’s benefits by providing quality healthcare services that meet professionally recognized standards of care, are a covered benefit, medically necessary and appropriate for the individual member’s condition and provided at the most appropriate level of care. Our UM Program includes the following:

Preauthorization (Prior Authorization)

“Preauthorization” is defined as a process through which the physician or other healthcare provider is required to obtain advance approval from the plan for any covered item or service. Preauthorization applies to all elective and/or scheduled services on Humana’s preauthorization list and must be obtained before the services are rendered.

Preauthorization is required or notification is requested for certain medications and medical services under most Humana plans. Requests should be made as soon as possible but at least 10 days prior to the proposed service date. Services that require preauthorization can be found on our website. Providers should review the Humana preauthorization and notification list on our website or call Customer Service (1-800-4HUMANA) to obtain a copy of the preauthorization and notification list.

Humana’s preauthorization and notification list is subject to change each month. New-to-market drugs may be added to the list of medications which require review. Humana also reviews and may update the preauthorization and notification list at least biannually. Changes to the preauthorization list outside of the new-to-market drugs are communicated through notices to providers in accordance with provider agreements.

Emergent/Urgent care services do not require preauthorization. However, providers should notify Humana within one calendar day of the initiation of these services.

If a healthcare provider does not obtain preauthorization for a service, it could result in financial penalties/payment denials for the practice and reduced benefits for the patient, based on the healthcare provider’s contract and the patient’s certificate of coverage.

Services or medications provided without preauthorization may be subject to retrospective medical necessity review – a written summary of medical necessity and services provided stating why proper authorization was not obtained must be submitted by the provider.

We recommend that an individual practitioner making a specific request for services or medications verify benefits and preauthorization requirements with Humana prior to providing services.

Notification

“Notification” refers to the process of the physician or other healthcare provider notifying Humana of the intent to

provide an item or service. Humana requests notification, as this helps coordinate care for your Humana-covered patients. This process is distinguished from preauthorization. Humana does not issue an approval or denial related to a notification.

How to Request a Preauthorization

To initiate a preauthorization or notification request, a provider may:

- Visit [Availity.com](https://www.availity.com)
- Use our interactive voice response system (IVR) by calling 1-800-523-0023
- Call the number for precertification on the back of the member's ID card
- Fax the request to 1-855-227-0677

When a member's life, health or ability to regain maximum function is in serious jeopardy, you should immediately submit an expedited authorization request by calling 1-800-523-0023.

Information Required

Information required for a preauthorization request or notification may include but is not limited to:

- Member's ID number, name and date of birth
- Date of actual service or hospital admission
- Procedure codes, up to a maximum of 10 per authorization request
- Date of proposed procedure, if applicable
- Diagnosis codes (primary and secondary), up to a maximum of six per authorization request
- Service location – inpatient or outpatient
- Tax ID number of treatment facility where service is being rendered
- Tax ID number of the provider performing the service
- Applicable ICD diagnosis code
- Caller's telephone number
- Attending physician's telephone number
- Relevant clinical information
- Discharge plans

Submitting all relevant clinical information at the time of the request will facilitate a more expeditious determination. If additional clinical information is required, a Humana representative will request the specific information needed to complete the authorization process.

For Medicare Advantage (MA) plans: Advanced Coverage Determinations (ACD)/Predeterminations and Advanced Beneficiary Notice (ABNs)

CMS does not permit any provider to use the Advanced Beneficiary Notice (ABN) for a Medicare Advantage plan enrollee. However, as with Original Medicare, if a provider believes that a specific service might not be covered, CMS expects that provider to share that information with the member before providing the service. Note that, for contracted providers particularly, CMS has established very specific requirements for such services. Before providing a service that might not be covered, you should call Humana to request an ACD/predetermination, unless the member's plan certificate clearly indicates that the service is one that is never covered.

For procedures or services that are investigational, experimental or may have limited benefit coverage, or for questions regarding whether Humana will pay for any service, you may request an ACD on behalf of the patient prior to providing the service. You may be contacted if additional information is needed.

ACDs for medical services may be initiated by submitting a written request, fax or telephone request:

- Send written requests to the following:
Humana Correspondence
P.O. Box 14601
Lexington, KY 40512-4601
- Submit by fax: 1-800-266-3022
- Submit by telephone: 1-800-523-0023

ACDs for medications on the list may be initiated by submitting a fax or telephone request:

- Submit by fax: 1-888-447-3430
- Submit by telephone: 1-866-461-7273

Referrals

For members with HMO plans, referrals may be required. If a member requires specialized treatment beyond the scope of a primary care physician (PCP), the member may be referred to a specialist for consultation and/or treatment; Humana contracts with specialists in the plan's service area.

The PCP initiates the referral by submitting a referral request through Availity.com or by using Humana's Referral Request form, which is available on Humana.com, providers' section. Methods for submitting referral requests are outlined in the "Preauthorization" section above and on Humana's website. The primary care physician (PCP) will receive a referral number from Humana if the referral request is: 1) Completed and Humana determines the services are covered under the provider agreement; 2) Provided by an approved provider/facility; and 3) Medically necessary. An approved referral number does not override member eligibility, provider agreement exclusions, etc. Prior to the specialist rendering services, preauthorization must also be obtained by the specialist for any additional medications or medical services on the preauthorization and notification list.

The status of a referral can be verified by accessing Availity.com or by telephone (1-800-523-0023). After the member has been treated, the specialist's findings, diagnosis and recommendation for treatment should be sent to the member's PCP. The specialist must also submit claim/encounter data to Humana.

Referrals are not required for members with PPO plans. Preauthorization for medications and medical services on the preauthorization and notification list is required. You will find the "Preauthorization and Notification list" on Humana.com, providers' section or a copy may be requested from Humana Customer Service (1-800-4HUMANA).

Note: Original Medicare does not cover some services or supplies when they are ordered/referred unless certain requirements (e.g., qualifications of the ordering/referring provider, billing requirements) are satisfied. For Medicare Advantage members, Humana follows Original Medicare billing and enrollment requirements for services and supplies covered under Original Medicare.

Inpatient Coordination of Care/Concurrent Review

Concurrent review is the process that determines coverage during the inpatient stay, including, but not limited to, acute inpatient facility, skilled nursing facility (SNF), long-term acute care hospital (LTAC), inpatient rehabilitation facility and behavioral health partial hospital/residential treatment facilities. Each admission will be reviewed for medical necessity and compliance with contractual requirements. Humana will contact the provider if additional clinical review is required. In addition to the information provided for the initial admission, providers should indicate any complicating factors

that prevent discharge. Providers must also contact Humana with the discharge date and discharge disposition upon member discharge.

For certain plans, in the event coverage guidelines for an inpatient stay are not met and/or the member's certificate does not provide the benefit, a licensed medical professional from Humana will consult with the PCP and/or facility utilization management and discharge planning staff. If necessary, the licensed medical professional will refer the case to a Health plan medical director for review and possible consultation with the attending physician. If the medical director determines that coverage guidelines for continued hospitalization are no longer validated, the member, attending physician, hospital and the member's primary care office, as appropriate, will be notified in writing that benefits will not be payable if the member remains in the hospital on and after the effective date of the non-approval.

Discharge Planning

The Humana UM team collaborates with the member/member's family or guardian, the hospital's UM and discharge planning departments and the member's attending physician/PCP to facilitate the member's discharge plan, including identifying the most appropriate post-discharge level of care.

Clinical Review Guidelines

Humana uses nationally accepted clinical guidelines to determine the medical necessity of services. The review guidelines are used as a screening guide to approve services during the utilization management process.

For Medicare Advantage plans, Humana also applies National Coverage Determinations (NCD) and Local Coverage Decisions (LCD). Specific to reviews for commercial plans, Humana develops internal clinical policies, Humana Medical Coverage Policies (HMCPs), based on peer-reviewed literature. Humana's Medical Coverage Policies are available on Humana.com, providers' section.

A licensed and board-certified medical director reviews all available clinical documentation and records to evaluate potential medical necessity denials. The medical director renders a decision in accordance with clinical review guidelines and currently accepted medical standards of care, taking into account the individual circumstances of each case. Providers may obtain the guidelines used to make a specific adverse determination by contacting Humana.

Peer-to-peer Review

Prior to or at the time an adverse determination is communicated, the practitioner ordering services may be given an opportunity to discuss the services being requested for the member and the clinical basis for treatment with a medical director or other appropriate reviewer.

Note: There are exceptions based on federal and state regulations – see below.

Medicare Advantage Plans:

For Medicare Advantage plans, the discussion must be completed prior to the adverse determination being rendered. Once an adverse determination has been made, participating providers are given the opportunity to submit a provider dispute. A participating provider may submit a dispute prior to submitting a claim under the following circumstances.

- Physician/provider is contracted with Humana.
- Humana's adverse determination was based on lack of medical necessity for an authorization request that was retrospective (retro) or concurrent to the service.
- Physicians/providers will have five calendar days from notification of the denied authorization to request the pre-claim dispute.

As part of this pre-claim dispute, a peer-to-peer conversation may be requested if one did not occur prior to the adverse

determination. Participating providers also may submit claim disputes. See the Provider Claims Dispute Process section of this manual.

Commercial Plans:

For commercial plans sold in Texas and Arizona, state regulations mandate that the peer-to-peer discussion must be completed prior to the adverse determination being rendered. Participating providers may submit a claim dispute. See the Provider Claims Dispute Process section of this manual.

Second Medical Opinions

A member has the right to a second medical opinion in any instance in which the member questions the reasonableness, necessity, or lack of necessity for the following:

- Surgical procedures
- Treatment for a serious injury or illness
- Other situations in which the member feels that he/she is not responding to the current treatment plan in a satisfactory manner

HMO members may obtain a second opinion by another participating physician but the PCP must issue a referral. The final treatment plan is determined by the member's PCP. Follow-up services must be obtained through or arranged by the member's PCP.

Special Requirements for Hospitals – Medicare Advantage (MA) plan members

Hospital Discharge Rights for Medicare Advantage members

The Centers for Medicare & Medicaid Services (CMS) requires that hospitals deliver the Important Message from Medicare (IM), CMS-R-193, to all Medicare beneficiaries, including Medicare Advantage (MA) plan members who are hospital inpatients. Hospitals are required to provide the IM to the MA member upon admission and at least two days prior to the anticipated last covered date. The notice must be given on the standardized CMS IM form. The form and instructions regarding the IM may be found on the CMS website at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>.

The IM informs hospitalized MA beneficiaries about their hospital discharge appeal rights. MA members who are hospital inpatients have the statutory right to request an "immediate review" by a quality improvement organization (QIO) when Humana, along with the hospital and physician, determines that inpatient care is no longer necessary.

Guidelines for Important Message from Medicare (IM) notification by telephone:

If the hospital staff is unable to personally deliver the IM to the patient or his or her representative, then the hospital staff should telephone the patient or representative to advise him or her of the member's rights as a hospital patient, including the right to appeal a discharge decision.

At a minimum, the telephone notification should include:

- The name and telephone number of a contact at the hospital
- The beneficiary's planned discharge date and the date when the beneficiary's liability begins
- The beneficiary's rights as a hospital patient, including the right to appeal a discharge decision
- How to get a copy of a detailed notice describing why the hospital staff and physician believe the beneficiary is ready to be discharged

- A description of the steps for filing an appeal
- When (by what time/date) the appeal must be filed to take advantage of the liability protections
- To whom to appeal, including any applicable name, address, telephone number, fax number or other method of communication the entity requires to receive the appeal in a timely fashion

Note: The date that the hospital staff conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice.

The hospital is required to:

- Confirm the telephone contact by written notice mailed to the member's authorized representative on that same date.
- Place a dated copy of the notice in the member's medical file and document the telephone contact with either the member or his or her representative on either the notice itself or in a separate entry in the member's file.
- Ensure that the documentation indicates that the staff person told the member or representative the planned discharge date, the date that the beneficiary's financial liability begins, the beneficiary's appeal rights and how and when to initiate an appeal.
- Ensure that the documentation includes the name of the staff person initiating the contact, the name of the member or representative contacted by phone, the date and time of telephone contact and the telephone number called.

When direct phone contact with a member or a member's representative cannot be made, the hospital must:

- Send the notice to the member or representative by certified mail, return receipt requested or via another delivery method that requires signed verification of delivery. The date of signed verification of delivery (or refusal to sign the receipt) is the date received.
- Place a copy of the notice in the member's medical file and document the attempted telephone contact to the member or representative.
- Ensure that the documentation includes:
 - The name of the staff person initiating the contact
 - The name of the member or member's representative
 - The date and time of the attempted call
 - The telephone number called

Right to appeal a hospital discharge:

When members choose to appeal a discharge decision, the hospital or their Medicare health plan must provide them with the Detailed Notice of Discharge (DND). These requirements were published in a final rule, CMS-4105-F: Notification of Hospital Discharge Appeal Rights, which became effective on July 2, 2007.

When the QIO notifies the hospital and Humana of an appeal, Humana will provide the hospital with a DND. The hospital is responsible for delivering the DND as soon as possible to the member or his or her authorized representative on behalf of Humana, but no later than noon local time of the day after the QIO notifies Humana or the hospital of the appeal. The facility must fax a copy of the DND to the QIO and to Humana.

If the member misses the time frame to request an immediate review from the QIO and remains in the hospital, he or she may request an expedited reconsideration (appeal) through Humana's appeals department. For more information about notification of termination requirements, practitioners may visit the CMS website at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>.

Medicare Outpatient Observation Notice (MOON) Requirement

The Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE ACT) Public Law 114-42 was passed on Aug. 6, 2015 and amended Section 1866(a)(1) of the Social Security Act. The amendment requires hospitals and critical access hospitals (CAHs) to provide the Medicare Outpatient Observation Notice (MOON) to Original Medicare beneficiaries and Medicare Advantage (MA) plan members or their authorized representatives. This includes beneficiaries who do not have Part B coverage, beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON and beneficiaries for whom Medicare is the primary or secondary payer. The MOON is intended to inform beneficiaries who receive observation services for more than 24 hours that they are outpatients, not inpatients and the reasons for their status.

Important information:

- Effective as of March 8, 2017, hospitals and CAHs are responsible to provide the written MOON and a verbal explanation of the notice to all Original Medicare and MA beneficiaries who receive outpatient observation services for more than 24 hours.
- The MOON must be provided to the beneficiary (or the beneficiary's authorized representative) no later than 36 hours after observation services begin and may be delivered before a beneficiary receives 24 hours of observation services as an outpatient.
- If the beneficiary is transferred, discharged or admitted, the MOON still must be delivered no later than 36 hours following initiation of observation services.
- The start time of observation services is measured as the clock time observation services are initiated in accordance with a physician's order.
- Hospitals and CAHs must use the Office of Management and Budget (OMB)-approved MOON (CMS-10611) and instructions available on the CMS website at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI> (opens in new window).

Additional information about the MOON can be found on the CMS Medicare Learning Network site (MLN Matters Number: 9935) at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9935.pdf>

Special Requirements for Skilled Nursing Facilities (SNFs), Home Health Agencies (HHA) and Comprehensive Outpatient Rehabilitation Facilities (CORFs) – Medicare Advantage (MA) plan members

Notice of Medicare Non-Coverage (NOMNC):

The Centers for Medicare & Medicaid Services (CMS) requires that physicians and other healthcare providers give the Notice of Medicare Non-Coverage (NOMNC) to Medicare Advantage (MA) health plan members at least two days prior to termination of skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services. Additionally, if the member's SNF services are expected to be fewer than two calendar days, the NOMNC should be delivered at the time of admission. For HHA or CORF services, the notice needs to be given no later than the next to the last time services are furnished. The NOMNC informs members how to request an expedited determination from their quality improvement organization (QIO) if they disagree with the termination.

The form and instructions regarding the NOMNC are available on the CMS website at: <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>

Practitioners also may contact their QIO for forms or additional information. A form may also be obtained from Humana's local health services utilization management department. No modification of the text on the CMS NOMNC is allowed. For the NOMNC to be valid:

- The member must be able to comprehend and fully understand the notice contents.

- The member or his or her authorized representative must sign and date the notice as proof of receipt.
- The notice must be the standardized CMS NOMNC form.

If a member refuses to sign the NOMNC, the member's refusal to sign, the date, time, name of person who witnessed the refusal and his or her signature must be documented on the NOMNC. Valid delivery does not preclude the use of assistive devices, witnesses or interpreters for notice delivery. Any assistance used with delivery of the notice also must be documented. If a member is not able to comprehend and fully understand the NOMNC, a representative may assume responsibility for decision-making on the member's behalf; in such cases, the representative, in addition to the member, must receive all required notifications. The following specific information is required to be given when contacting a member's representative of the NOMNC by phone:

- The member's last day of covered services and the date when the beneficiary's liability is expected to begin.
- The member's right to appeal a coverage termination decision.
- A description of how to request an appeal by a QIO.
- The deadline to request a review, as well as what to do if the deadline is missed.
- The telephone number of the QIO to request the appeal.

The date when the information is verbally communicated is considered the NOMNC's receipt date. Practitioners must document the telephone contact with the member's representative on the NOMNC on the day that it is made, indicating that all of the previous information was included in the communication. The annotated NOMNC also should include:

- The name of the staff person initiating the contact
- The name of the representative contacted by phone
- The date and time of the telephone contact
- The telephone number called

A dated copy of the annotated NOMNC must be placed in the member's medical file, a copy mailed to the representative the same day as the telephone contact and a copy faxed to the practitioner's local Humana health services utilization management department.

Right to appeal a NOMNC (Fast-track Appeal):

CMS offers fast-track appeal procedures to Medicare enrollees, including MA members, when coverage of their SNF, HHA or CORF services are about to end. CMS contracts with QIOs to conduct these fast-track appeals. When notified by Humana or the QIO that the member has requested a fast-track appeal, SNFs, HHAs and CORFs must:

- Provide medical records and documentation to Humana and the QIO, as requested, no later than close of the calendar day on which they are notified. This includes, but is not limited to, weekends and holidays.
- Deliver the Detailed Explanation Non-Coverage (DENC) form that is provided by Humana (or that is delegated to the practitioner to complete) to members or their authorized representatives no later than close of the calendar day on which they are notified including on weekends and holidays. The DENC provides specific and detailed information concerning why the SNF, HHA or CORF services are ending.

If a member misses the time frame to request an appeal from the QIO, the member still can appeal through Humana's appeals department.

For more information about notification of termination requirements, practitioners may visit the CMS website at: <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>.

V. Office Procedures

This section provides policies and procedures that pertain to the daily operations of a provider office.

Office Appointment and Wait Times: In part to coincide with providers' commitment to assist Humana with its performance and quality management, providers shall implement procedures and make reasonable efforts to ensure that:

- Members are seen by a clinician within 15 minutes of the member's appointment time.
- Routine and follow-up appointments are made within 30 calendar days.
- Urgent appointments are made within 24 hours, seven days per week.
- Urgently needed services must be provided immediately for Medicare members.
- Emergent appointments are made immediately (arrange for on-call or after-hours coverage), 24 hours per day, seven days per week.
- The standards should consider the enrollee's need and common waiting times for comparable services in the community. Examples of reasonable standards for primary care services are: (1) urgently needed services or emergency – immediately; (2) services that are not emergency or urgently needed, but in need of medical attention – within one week; and (3) routine and preventive care – within 30 days.

Address Change or Other Practice Information

For Humana to maintain accurate participating provider directories and for reimbursement purposes, providers **are contractually required** to report all changes of address or other practice information electronically via Humana.com or in writing as soon as possible. Notices of any changes must adhere to time frames outlined in the agreement.

If a provider's agreement with Humana is through a management services organization (MSO), independent practice association (IPA), or provider medical group, these changes can be communicated to Humana through the entity rather than by the individual provider.

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

- Provider demographic information
- Tax identification number*
- National Provider Indicator (NPI)
- Address
- Office hours
- Phone number
- Practice name
- Adding a provider – provider joining practice/group**
- Provider deletions – provider no longer participating with the practice/group
- Patient restrictions (age, gender, etc.)
- Accepting new patients
- Medicare numbers
- Hospital privileges

*Changes in practice name, legal entity or tax ID numbers may require an amendment, assignment or new agreement, depending on the reason for the change. Check with the provider representative in the local Humana office for specific information.

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

Humana requires that changes such as those outlined above be submitted at least 30 days prior to the effective date of the change to facilitate accurate directory information and claims payment.

VI. Medical Records

Medical Records: Humana provider representatives must be permitted access to the provider's office records and operations. This access allows Humana to monitor compliance with regulatory requirements. Each provider office will maintain complete and accurate medical records for all Humana members receiving medical services in a format and for time periods as required by the following:

- Applicable state and federal laws
- Licensing, accreditation and reimbursement rules and regulations to which Humana is subject
- Accepted medical practices and standards
- Humana's policies and procedures

Note: Humana has adopted guidelines based on federal and state medical record documentation requirements. These are available at Clinical Practice Guidelines/Providers on Humana.com.

The provider's medical records must be available for utilization, risk management, peer review studies, customer service inquiries, grievances and appeals processing, claims disputes and other initiatives Humana may be required to conduct. To comply with accreditation and regulatory requirements, Humana may periodically perform a documentation audit of some provider medical records. The provider must meet 85 percent of the requirements for medical record keeping with a goal of 90 percent, or per applicable state and federal requirements if more stringent.

The participating provider must respond to the Humana member grievance and appeal unit expeditiously with submission of the required medical records to comply with time frames established by CMS and/or the state department of insurance for the processing of grievances and appeals. Only those records for the time period designated on the request should be sent. A copy of the request letter should be submitted with the copy of the record. The submission should include test results, office notes, referrals, telephone logs and consultation reports. Medical records should not be faxed to the local Humana market office unless provider can ensure confidentiality of those medical records.

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

For HMO plans, if a plan member changes his/her PCP for any reason, the provider must transfer a copy of the member's medical record to the member's new PCP at the request of the plan or the member.

The agreement states whether the original or a copy of the medical record must be sent. If a provider terminates, the provider is responsible for transferring the members' medical records.

Charges for copying medical records are considered a part of office overhead and are to be provided at no cost to members and Humana, unless state regulations or the agreement stipulate otherwise.

VII. Provider Claims Dispute Process, Member Grievance/Appeal Process and Provider Termination Appeal Process

Provider Claims Dispute Process

For All Products:

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

Phone: 1-800-4-HUMANA

Address: Humana Correspondence PO Box 14601

Lexington, KY 40512

When sending in a written request for dispute/reopening, a provider may contest the payment denial or nonpayment of a claim with a minimum of the following information:

- Provider name
- Tax ID
- Member name and identification number
- Date of service
- Relationship of the member to the patient
- Claim number
- Charge amount
- Payment amount
- Proposed correct payment
- Difference between the amount paid and the proposed correct payment amount
- Brief description of the basis for the contestation.

In addition, be sure to include any relevant supporting documentation (medical records, copy of invoice, etc.).

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

See the providers' section of Humana.com for Humana's [claims payment policies](#) and further information about claims disputes.

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

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

Member Grievance/Appeal Process

The grievance/appeal process applies to **members** of commercial plans and Medicare Advantage members who are dissatisfied with the healthcare services received, or any aspect of the plan, or who have received an adverse determination.

A commercial plan grievance/appeal may be filed by a current or former member or his/her authorized representative if the date of service for the appeal issued was rendered while the member's benefits were still active. Unless otherwise mandated by state law, providers for commercial members may file on behalf of the member and utilize the member's grievance/appeal process by obtaining written authorization from the member.

A Medicare plan grievance may be filed by current or former member or his/her authorized representative.

A Medicare Advantage plan member, representative, or physician may appeal preservice denials as long as the member is notified.

A nonparticipating provider may only appeal claim denials with a waiver of liability form for the following:

- Full claim denials
- Claims paying zero dollars
- Claims denied for medical necessity
- Claims denied for non-covered benefits

A Medicare Prescription Drug plan (PDP) member, representative, the prescribing physician, or other prescriber may request an appeal. The member's prescribing physician and other prescribers have the right to file a standard redetermination request on behalf of the member as long as the member is notified. An Appointment of Representative (AOR) is not required.

Humana will accept members' and/or physicians' requests for expedited/urgent appeals for Medicare Advantage members and by prescribing providers if the member is a Medicare Part D plan member. The member's treating physician has the right to file a standard preservice appeal request on behalf of the member as long as the member is notified and an AOR is not required for MA plan members.

For commercial plan members, Humana will accept members' and/or providers' requests for expedited/urgent appeals, including prescribing physicians. Also, certain states and federal programs may have specific processes for physician grievance/appeal requests.

If the initial grievance/appeal is upheld, the resolution letter will provide next level rights as applicable. Additional details regarding commercial and Medicare Advantage appeals on behalf of members are set forth below.

Commercial Appeals

Commercial Appeals Definitions of Terms:

Adverse Determination: A denial, reduction, termination of, or failure to provide a service or make payment:

- In whole or part for a benefit (Example: applying the plan provisions and paying less than the total amount of expense submitted for a deductible, coinsurance or copayment)
- For group plans, based on eligibility to participate in the plan (when a claim or appeal is made)
- For individual plans, based on eligibility to participate in the plan
- Based on rescission of coverage

Expedited/Urgent Appeal: a verbal or written request for a fast or rush appeal from a member, representative, or physician to appeal a service denial, termination of care, or a reduction in the level of care. An appeal will be expedited when the determination, if processed according to the standard appeal time frames, could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or would cause the member to have severe pain that cannot be adequately managed without the requested care or treatment.

Independent/External Review Organization (IRO): An external company designated to provide an independent review, either affiliated with a state agency or an external review entity contracted by Humana to independently review appeals upon request.

Second-level Appeal: A formal request for dispute of an appeal of an adverse determination. If the member submits an appeal and the denial is upheld following the review, the member may be eligible to request a second-level appeal depending upon the member's specific benefits and/or state regulatory requirements.

Specialty Review: A review conducted by a healthcare provider who typically manages the medical condition, procedure or treatment under review for clinical appeals.

Standard Appeal: A formal request for dispute of an adverse determination.

Commercial Appeals Process

Humana will accept and process any written appeal from a member or the member's authorized representative expressing dissatisfaction with Humana's adverse determination. Verbal appeals are accepted if required by the state or for reasons of illiteracy, handicap, or if the member is too ill to write.

If the initial determination is upheld during the appeal process, the resolution letter from Humana will provide the appropriate information on next level rights, if available, such as a second level or external review.

Appeals may include:

- Medical necessity denials;
- Benefit denials;
- Claim denials that affect the payment of a deductible, coinsurance or copayment; (**Note:** claim denials are not subject to the expedited appeal process.)
- Termination or reduction of care or benefits

Humana will identify and remove any communication barriers that may impede member from effectively making appeals. Humana will facilitate the request to file an appeal for a member who has a communication challenge affecting his/her ability to communicate or read through the following means:

- The TTY line is available for the hearing impaired;

- A translation service will be used for members unable to speak English if an in-house translator is not available; and
- Additional accommodations will be made for any member with special needs who is unable to follow the standard process

Humana will provide a full and fair review of the appeal. All appeal reviews will be conducted by a reviewer possessing the following characteristics:

- Did not participate in the initial decision; and
- Is not a subordinate of the individual who made the initial decision

In addition to the above requirements, appeal reviews for medical necessity, experimental and investigational will include a specialty review by a reviewer who is from the same or similar specialty, who typically treats the medical condition or provides the treatment in question and holds an active, unrestricted medical license.

Appeals should be submitted within 180 days of the date that member receives the adverse determination (see Note 1 below). Member may provide Humana with additional information that relates to the adverse determination and member may request copies of information that Humana has that pertains to the appeal. Humana will notify member of its decision within 72 hours for expedited appeals or within 30–60 days for standard appeal of receiving the request (see Note 2 below).

Note 1: Unless member’s plan or any applicable state law allows additional time.

Note 2: Some states or plans allow more (or less) time for Humana’s decision. See member’s benefit plan document for any state or plan specific appeal time frames or processes.

Procedures for Additional Level for Commercial Appeals

If the appeal is upheld, some states or plans may allow for a second level and/or a review by an Independent Review Organization. The resolution letter for the first level appeal will provide specific information regarding additional levels of review available to members.

Medicare Appeals

Medicare Appeals – Definition of Terms:

Authorized Representative: an individual either appointed by a member or authorized under state or other applicable law to act on behalf of the member in obtaining an organization/coverage determination, or grievance or appeal determination.

Expedited/Urgent Appeal: A verbal or written request for a fast appeal review of a preservice denial, termination of care, or a reduction in the level of care if the time frame for a standard appeal could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, or care or treatment that if not rendered could subject the member to severe pain that cannot be adequately managed, based on the opinion of a practitioner with knowledge of the member’s medical condition. Expedited appeals exclude requests for payments for services already provided.

Independent Review Entity (IRE): an independent entity contracted by CMS to provide an independent review of a plan’s appeal decision.

Reconsideration (MA appeal): the first step in the appeal process after an adverse organization determination; a Medicare health plan or independent review entity may reevaluate an adverse organization determination, the findings upon which it was based and any other evidence submitted or obtained.

Redetermination (PDP appeal): the first level of the appeal process which involves a Part D plan reevaluating an adverse coverage determination, the findings upon which it was based and any other evidence submitted or obtained.

Medicare Appeals Process

Humana will accept and process any PDP or Medicare Advantage appeal from a member or an authorized representative expressing dissatisfaction with Humana's adverse determination. In addition, Humana will accept and process any additional evidence or allegations of law and fact related to the disputed issue.

Humana will identify and remove any communication barriers that may impede members or representatives from effectively making appeals. Humana will facilitate the request to file an appeal for a member who has a communication challenge affecting his/her ability to communicate or read through the following means:

- The TTY line is available for the hearing impaired;
- A translation service or in-house translator will be used for members unable to speak English; and
- Additional accommodations will be made for any member with special needs who is unable to follow the standard process

Humana will provide a full and fair review of the appeal including specialty review for clinical appeals. Appeals must be submitted within 60 calendar days from the date of the adverse determination notice, unless the member can demonstrate good cause.

Medicare Advantage plans: Notification of the decision will be issued within the following time frames from the date of receipt of the request:

- Expedited – As expeditiously as the member's health condition requires, but no later than 72 hours
- Preservice – As expeditiously as required based on the member's health, but no later than 30 calendar days
- Postservice – 60 calendar days from the receipt of the request

Time frames for decisions may be extended for expedited and preservice appeals up to 14 calendar days if the:

- Member requests the extension
- Humana justifies the necessity for additional information and documents that it is in the best interest of the member

The extension notification to the member must occur prior to the expiration of the decision time frame and must include the right to file an expedited grievance if the member disagrees with the extension.

Medicare Prescription Drug plans: Notification of the decision will be issued within the following time frames from the date of receipt of the request:

- Expedited – As expeditiously as the member's health condition requires, but no later than 72 hours
- Standard – Seven calendar days

If the initial determination is upheld during the appeal process, the resolution letter from Humana will provide additional information on next-level appeals.

Provider Termination and Appeal Process

Termination Without Cause: As required by law, Humana shall notify a provider in advance of terminating his/her agreement. The notification time frames are defined in the agreement and/or applicable state and federal regulations. Humana has the right to terminate any individual provider or provider location, or line of business within the time frames specified in the termination process of the agreement, unless otherwise stated by state or federal law.

Should a provider, IPA, or PHO elect to terminate network participation, a notice of the pending termination must be forwarded to Humana in accordance to the terms of the agreement and applicable state and federal regulations.

Note 1: Humana has an established policy and procedures to notify members in advance of an impending termination of any provider. Advance notice is required by Humana to comply with all federal and state laws, rules and regulations, as well as accreditation agencies, regarding the notification to all members affected by the termination of a provider.

Note 2: Humana reviews the Department of Health and Human Services' (HHS) opt-out list, the CMS preclusion list and the OIG's sanction list as often as required by federal regulations. Should a provider's name appear on a current OIG-excluded provider listing, Humana will take immediate action to terminate the provider's network participation and, if applicable, take appropriate corrective actions. No hearing is allowed. Other sanctions (e.g., loss of professional license) also are grounds for immediate termination.

Note 3: The termination appeal process is to be considered in conjunction with the termination rights set forth in provider's agreement and, where applicable, state and federal law and regulations.

Medicare Advantage

In accordance with Medicare regulations found at 42 C.F.R. §422. 202, physicians have the right to a review of a termination decision by a physician review panel. The physician must submit a written request for this panel review within 30 calendar days of the date of notice of termination or physician's rights to this review will be waived.

The request must be addressed to the party identified in the termination notice letter and must be sent by either registered or certified mail. The request should include any relevant written information to be considered by the physician review panel. However, the physician review panel will consider only the written information submitted. The review will be held prior to the effective date of this termination. The physician review panel shall present a written decision to the physician via certified or registered mail.

Commercial Plans

Unless otherwise mandated by state law or regulations, or the agreement, the above provider termination appeal process applies only to Medicare Advantage providers.

VIII. Covered Services

A service must be medically necessary and covered by the member's contract to be paid by the plan. The plan determines whether services are medically necessary as defined by either the member's summary plan description, certificate of insurance or evidence of coverage. To verify covered or excluded services, call Humana Customer Service at the number listed on the back of the member's ID card, or verify benefits on the Availity Provider Portal. All services may be subject to applicable copayments, deductibles and coinsurance.

Humana uses the current, nationally approved criteria for any medical necessity reviews required. For commercial plans, Humana has developed its own medical/pharmacy coverage policies.

Humana makes coverage determinations, including medical necessity determinations, based upon its member's summary plan description, certificate of insurance or evidence of coverage. However, Humana is not a provider of medical services and it does not control the clinical judgment or treatment recommendations made by the providers in its networks or otherwise be selected by members. Providers make independent healthcare treatment decisions.

IX. Clinical Practice Guidelines

Humana provides Web links to [clinical practice guidelines](#) developed by nationally recognized organizations, which are reviewed and updated accordingly. The guidelines are available at Humana.com, providers' section.

X. Compliance/Ethics

Liability Insurance

Upon request, all providers must provide Humana with evidence of insurance coverage in accordance with their agreement's requirements.

Compliance and Fraud, Waste and Abuse Requirements

Contracted providers and those they employ and/or contract to support a contract with Humana are responsible for complying with all applicable laws, regulations and Humana's policies and procedures. Those who provide services for Humana's Medicare- and/or Medicaid-eligible members, as well as those they employ or contract, also must comply with requirements outlined in Humana's Compliance Policy and Standards of Conduct documents.

Note: The above two documents also contain sufficient guidance on fraud, waste and abuse (FWA), so they can be used for FWA training and are available on Humana's website.

These documents incorporate requirements outlined by the government:

- **CMS** for all sponsors, individuals and entities that perform a function or service in support of Medicare Advantage or prescription drug plans, as detailed in Chapter 21 of the Medicare Managed Care Manual and Chapter 9 of the Prescription Drug Benefit Manual.
- **States** where Humana has a contract to administer one or more plans for Medicaid-eligible beneficiaries.

Compliance and FWA requirements include, but are not limited to those outlined in these seven elements of an effective compliance program:

I: Written Policies, Procedures and Standards of Conduct

II: Compliance Officer, Compliance Committee and High Level Oversight

III. Effective Training and Education

Note: In addition to compliance and FWA training, your organization must conduct for those supporting Medicare and/or Medicaid plans administered by Humana, training is required for those performing a function or providing services for a Medicaid-eligible beneficiary in a state where Humana administers a Medicaid plan. Therefore, a corresponding Humana government contract may require training on one or more of the following topics:

- Cultural competency
- Health, safety and welfare of plan members
- Medicaid provider processes
- Humana orientation

IV. Effective Lines of Communication

A notable example of this is prior approval must be obtained from Humana for any new contract or changes to an existing agreement involving any relationships with downstream entities, within or outside of the United States, for support of a Humana-administered plan for beneficiaries eligible for Medicare and/or Medicaid. In addition, note that Humana must notify CMS of any location outside of the United States or a United States territory that receives, processes, transfers, stores or accesses Medicare member protected health information in oral, written or electronic form. Therefore, timely engagement of Humana is necessary to assure compliance with this CMS requirement.

V. Well-publicized Disciplinary Standards

VI. Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks

VII. Procedures and System for Prompt Response to Compliance Issues

1. To gain necessary familiarity with these compliance program elements, including Humana's compliance expectations, review Humana's Compliance Policy and Standards of Conduct documents, which are located on Humana's Website at [Humana.com/fraud](https://www.humana.com/fraud)

Reporting Methods for Suspected or Detected Noncompliance or FWA

Contracted providers, their employees and related entities are required to notify Humana of suspected or detected FWA or noncompliance.

Providers, their employees and downstream entities may report concerns and information related to FWA and noncompliance with this manual, Humana's Standards of Conduct and/or Compliance Policy to Humana via a number of confidential and anonymous options:

- Humana Special Investigations Unit (SIU) Phone Hotline: English 1-800-614-4126
- SIU Fax: 1-920-339-3613
- E-mail: siureferrals@humana.com
- Mail: Humana, Special Investigation Unit, 1100 Employers Blvd., Green Bay, WI 54344
- Ethics Help Line: 1-877-5-THE-KEY (1-877-584-3539)
- Ethics Help Line Reporting website: www.ethicshelpline.com
- Individuals and entities reporting suspected or detected false claims violations are protected from retaliation under 31 U.S.C. 3730(h) for False Claims Act complaints. Humana also has a policy of non-retaliation against those who in good faith report suspected or detected violations of Humana's policies and has zero tolerance for retaliation or retribution against any person who reports suspected misconduct or participates in a corresponding investigation.

Note: An individual with knowledge of fraud against the government may file a lawsuit (plaintiff) on behalf of the government against the person or business that committed the fraud (defendant). The filer of the lawsuit is also known as a "whistle blower."

- Retaliation against individuals for investigating, filing or participating in a whistle blower action is prohibited.
- If the action is successful, the plaintiff is rewarded with a percentage of the recovery.

Humana's SIU performs an initial investigation of suspected fraud and, if applicable, may refer the case to the appropriate law enforcement and/or regulatory agencies (including, but not limited to, the appropriate CMS regional office) as SIU deems appropriate.

Disciplinary Standards

Confirmed FWA and/or violations of Humana's Compliance Policy or Standards of Conduct documents or government law or regulations by healthcare providers and/or Humana's downstream entities could result in any or all of the following:

- Oral or written warnings or reprimands;
- Termination of an agreement;
- Other measures which may be outlined in the agreement;

- Mandatory retraining;
- Corrective action plan(s); and/or
- Reporting of the conduct to the appropriate external entity(s), such as CMS, a CMS designee and/or law enforcement agencies.

Reporting Occurrences

An occurrence is defined as any unforeseen complication or unusual event in which a member of a Humana health plan is involved. Examples of an occurrence include:

- Unexpected death of a member at the member's home, office or public place, particularly after a recent visit to the provider's office or facilities;
- Any complication related to a drug, treatment or service prescribed;
- Dissatisfaction angrily expressed by a member or their representative with threats related to medical care rendered by the provider;
- Breach of confidentiality and/or inappropriate release of protected health information (as defined under the Health Insurance Portability and Accountability Act);
- Requests for medical records by an attorney if the request is related to a potential medical negligence claim (Note: This does not cover medical records requests for workers' compensation and/or motor vehicle accidents); and/or
- Adverse outcomes to a member as a result of:
 - Surgery (such as brain or spinal damage)
 - Delayed scheduling or completing of a diagnostic test or procedure
 - Delay in diagnosis or referral process
 - Delay in reporting abnormal results
 - Diagnostic procedure
 - Prescribed medications (e.g., wrong drugs dispensed)
 - Any drug, treatment, or service prescribed
 - Surgical error and/or surgical procedure being performed on the wrong patient
 - Surgical procedure unrelated to the patient's diagnosis
 - Transplant management

Providers are expected to report any occurrence that happens to a plan member when visiting their offices, except for occurrences that take place in acute care, skilled nursing or rehabilitation facilities. Reporting occurrences inside acute care, skilled nursing and rehabilitation facilities is dictated by the operational procedures of each facility.

Report all occurrences to Humana as soon as possible, preferably within three business days of the occurrence. Occurrence reports for Humana health plan members can be reported to: RiskManagementAdministration@humana.com, or by contacting Provider Relations at 1-800-626-2741.

Note: In the state of Florida, occurrences must be received by the Humana risk manager within three calendar days, per Florida statute F.S. 59A-12.012. The information submitted to the health plan is used for state mandated risk management review. All information reported to the health plan will remain strictly confidential in accordance with Humana's policy and procedure on confidentiality.

Conflicts of Interest

A conflict of interest is a personal, familial or business relationship that could amount to, but is not limited to:

- Competing with any of Humana’s product offerings
- Providing services to a competitor of Humana
- Interfering with the performance of work duties

Therefore, healthcare providers are expected to:

- Have a policy to internally disclose any conflicts of interest annually and upon any change or addition to this status
- Communicate the above-mentioned policy to your employees and downstream entities
- Review potential conflicts of interest and either remove the conflicts or, if appropriate, grant approval to continue work despite the conflicts
- Comply with the following, if requested by Humana:
 - Provide information on conflicts of interest; and
 - Remove conflicts, up to removal of the person or entity that was performing any function(s) to meet contractual obligations to Humana

Medicare

Medicare Marketing Literature and Provider-sponsored Activities: For purposes of this manual, the term “Medicare Marketing” includes any information, whether oral or in writing, that is intended to promote or educate prospective or current Humana Medicare Advantage or prescription drug plan members about Humana or its Medicare plans, products or services. This includes, but is not limited to, any and all promotional materials used at provider-sponsored activities, such as open houses, health fairs and grand openings. Examples of promotional materials include letters, advertisements, invitations and announcements which use Humana’s name.

Medicare marketing must be approved through the Humana corporate review process prior to a provider conducting any Medicare marketing activity. The Humana corporate review process includes review by legal and regulatory compliance and filing through Humana’s Medicare product compliance department and CMS (as applicable), in accordance with CMS guidelines.

To obtain approved Medicare marketing materials or to arrange for a provider-sponsored activity, contact the Medicare sales director in the local Humana market office, sales and marketing support executive or physician marketing contact. Any misrepresentation of a Humana Medicare product or service, intentional or not, is a serious violation of Humana’s agreements with CMS.

Provider Affiliations: Providers may announce new or continuing affiliations for specific sponsors of Medicare Advantage or prescription drug plans through direct mail, email, telephone, or advertisement. New affiliation announcements are for those providers who have entered into a new contractual relationship with the sponsor of a Medicare Advantage or prescription drug plan. Providers may make new affiliation announcements within the first 30 days of the new contract agreement. The announcement must clearly state that the provider also may contract with other plans/Part D sponsors. Any affiliation communication materials that describe plan benefits, premiums or cost sharing must be approved by Humana and CMS prior to use.

Medicare HMO and PPO Coverage/Liability: If a **Medicare HMO member** disenrolls from a Medicare Advantage plan while in a SNF, costs for SNF services are covered by a new health plan or Medicare as of the effective date of the disenrollment. If a Humana Medicare Advantage member’s effective date of disenrollment occurs while the member is hospitalized (including, but not limited to, hospitalization in a rehabilitation hospital and long-term care facility), Humana is responsible for paying the contracted rate through the date of discharge, unless otherwise specified in the agreement.

As long as the **Medicare Advantage HMO member** resides in the service area, he/she is covered for services until the effective date of disenrollment. When a member is temporarily out of the service area (for up to six months), coverage is limited to urgently needed, emergency care, post-stabilization services following an emergency and renal dialysis until the member returns to the service area or the effective date of disenrollment. **Medicare Advantage PPO members** may receive participating benefits from any participating provider, nationwide, as well as out-of-network benefits.

Medicare Disenrollment for Cause: CMS guidelines allow a PCP to request a member's disenrollment "for cause" only if the member's behavior is disruptive, unruly, abusive, threatening or uncooperative to the extent that his/her continued membership would substantially impair the provider's ability to provide health services to that particular member or other patients. A member also may be disenrolled for other reasons including, but not limited to, if he/she fails to qualify for Medicare benefits, or fraudulently permits others to use his/her member ID card for services.

A member cannot be disenrolled based on the member's utilization (or lack of use) of services or because of mental or cognitive conditions (including mental illness and developmental disabilities), disagreement with a provider regarding treatment decisions, or as retaliation for a member's complaint, appeal or grievance. Before initiating a request to disenroll a member for cause, the provider and Humana must make a serious effort to resolve the problems, such as encouraging the member to change his/her behavior and must document the result of this action. If the behavioral problems are not resolved, the provider may initiate a request to disenroll the member by submitting the Request for Disenrollment for Cause form to the local Humana market office. The form is available through the local Humana market office or by calling Humana Provider Relations at 1-800-626-2741. CMS requires Humana to notify a Medicare member that the consequences of continued disruptive behavior could include disenrollment from the plan. **The health plan and provider must reasonably demonstrate that the member's behavior is not related to the use of prescribed medications, mental illness or cognitive conditions (including mental illness and developmental disabilities), treatment for a medical condition, or use (or lack of use) of the provider's medical services.**

Procedure for Requesting Disenrollment: A written Request for Disenrollment for Cause letter must be sent to the local Humana market office, along with supporting documentation as follows:

- Description of the member's age, diagnosis, mental status, functional status and social support systems
- Complete and detailed description of the member's behavior
- Efforts taken to resolve any problems and modify behavior
- Any extenuating circumstances
- Summary of the case and reason for disenrollment
- Copy of medical records
- Statements, as applicable, from other providers, office staff, members, or law enforcement agencies describing their experiences with the member.

Upon receipt, a Letter Confirming Receipt of Disenrollment Request is sent to the PCP. The information is reviewed for completeness and compliance with the Medicare member's evidence of coverage or the commercial member's certificate of coverage. If the issues are resolved, the request may be withdrawn.

If the request is deemed to have merit, it is forwarded to a health plan medical director for review and a decision. The provider is notified of the decision and may appeal the decision by resubmitting the request along with additional supporting documentation for a subsequent review.

If the member is a Medicare member, CMS requires the plan to notify the member of its intent to request CMS permission to disenroll the member and the plan's grievance procedures. The plan then notifies CMS and CMS makes the final decision on whether to allow disenrollment for cause of the member.

If the member is a commercial member, Humana works with the benefits administrator of the employer group to make a decision regarding disenrollment for cause. If the decision is made to disenroll the member for cause, Humana's director of customer service in the appropriate service center will notify the member by letter of the decision.

Member's Right to Report a Grievance: The member may request a review of the disenrollment decision by filing a grievance in writing.

Member Disenrollment: The disenrollment is effective the first day of the calendar month after the month in which the health plan gives the member written notice of the disenrollment, or as provided by CMS. The member remains the responsibility of the PCP until the member's effective date of disenrollment.

Specific Medicare Advantage Plan Requirements:

Providers must remain neutral when assisting with enrollment decisions and may not:

- Accept/collect scope of appointment forms; accept Medicare enrollment applications
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider
- Mail marketing materials on behalf of plan sponsors
- Offer anything of value to induce plan enrollees to select them as their provider
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
- Conduct health screening as a marketing activity
- Accept compensation from the plan for any marketing or enrollment activities

Providers may:

- Distribute unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the “Medicare & You” handbook, or “Medicare Options Compare” (from <https://www.medicare.gov>) including in areas where care is delivered
- Provide the names of plan sponsors with which they contract and/or participate
- Provide information and assistance in applying for the Low-Income Subsidy
- Answer questions or discuss the merits of a plan or plans, including cost sharing and benefits information; these discussions may occur in areas where care is delivered
- Make available, distribute and display communication materials, including in areas where care is being delivered
- Provide or make available plan marketing materials and enrollment forms outside of the areas where care is delivered, such as common entryways, vestibules, hospital or nursing home cafeterias and community, recreation or conference rooms
- Refer patients to other sources of information, such as State Health Insurance Assistance Programs (SHIPs), plan marketing representatives, their state Medicaid office, local Social Security office, CMS' website at <http://www.medicare.gov/> or 1-800-MEDICARE
- Share information with patients from CMS' website, including the “Medicare and You” handbook or “Medicare Options Compare” (from <http://www.medicare.gov>), or other documents that were written by or previously approved by CMS

Humana is responsible for including certain CMS Medicare Advantage related provisions in the policies and procedures distributed to the providers that constitute Humana's health services delivery network. The following table summarizes these provisions, which may be accessed online by viewing the Code of Federal Regulations which is available on the U.S. Government Printing Office website (ecfr.gov):

Summary of CMS Requirements	CFR 42 (Section)
Safeguard privacy and maintain records accurately and timely	422.118
Permanent “out of area” members to receive benefits in continuation area	422.54(b)
Prohibition against discrimination based on health status	422.110(a)
Pay for emergency and urgently needed services	422.100(b)
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)
Direct access to mammography and influenza vaccinations	422.100(g)(1)
No copay for influenza and pneumococcal vaccines	422.100(g)(2)
Agreements with providers to demonstrate “adequate” access	422.112(a)(1)
Direct access to women’s specialists for routine and preventive services	422.112(a)(3)
Services available 24 hours a day, seven days a week	422.112(a)(7)
Adhere to CMS marketing provisions	422.80(a), (b), (c)
Ensure services are provided in a culturally competent manner	422.112(a)(8)
Maintain procedures to inform members of follow-up care or provide training in self-care as necessary	422.112(b)(5)
Document in a prominent place in medical record if individual has executed advance directive	422.128(b)(1)(ii)(E)
Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)
Continuation of benefits provisions (may be met in several ways, including contract provision)	422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)
Payment and incentive arrangements specified	422.208
Subject to applicable federal laws	422.504(h)
Disclose to CMS all information necessary to (1) administer and evaluate the program (2) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services	422.64(a): 422.504(a)(4) 422.504(f)(2)
Must make good faith effort to notify all affected members of the termination of a provider contract 30 calendar days before the termination by plan or provider	422.111(e)
Submission of data, medical records and certify completeness and truthfulness	422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)
Comply with medical policy, quality improvement and medical management	422.202(b); 422.504(a)(5)
Disclose to CMS quality and performance indicators for plan benefits re: disenrollment rates for beneficiaries enrolled in the plan for the previous two years	422.504(f)(2)(iv)(A)
Disclose to CMS quality and performance indicators for the benefits under the plan regarding enrollee satisfaction	422.504(f)(2)(iv)(B)
Disclose to CMS quality and performance indicators for the benefits under the plan regarding health outcomes	422.504(f)(2)(iv)(C)
Notify providers in writing for reason of denial, suspension and/or termination	422.202(d)(1)
Provide 60-day notice (terminating contract without cause)	422.202(d)(4)
Comply with federal laws and regulations including, but not limited to, federal criminal law, the False Claims Act (31 U.S.C. et Seq.) and the anti-kickback statute (section 1128B(b) of the act)	422.504(h)(1)
Prohibition of use of excluded practitioners	422.752(a)(8)
Adhere to appeals/grievance procedures	422.562(a)

XI. Product/Plan Overview

Health Maintenance Organization (HMO)

Health Maintenance Organization (HMO) plans require members to select a PCP to coordinate their care, but non-HMO plans recommend that members select a PCP. A PCP is usually from one of three disciplines:

- Family Physician – A physician who specializes in the care of all members of a family regardless of age.
- Internist – A physician who specializes in internal medicine and gives nonsurgical treatment of medical conditions.
- Pediatrician – A physician who specializes in the development, care and diseases of children

Note 1: In some states, an OBGYN who so elects also may qualify as a PCP.

Note 2: In certain circumstances, a certified nurse practitioner or physician's assistant may be designated as a "NP-PCP" or "PA-PCP" when the state regulations do not prohibit or set limitations on their scope of responsibility. In these cases, the NP-PCP or PA-PCP must be fully credentialed and contractually agree to assume responsibilities of a PCP for assigned members and comply with the terms and conditions of the agreement and this manual.

The HMO PCP agrees to accept plan members as stipulated by the agreement. The PCP must not refuse new members until such time he/she can reasonably demonstrate to the plan that his/her panel size has reached its maximum for adding new members. Further, the closing of the PCP's practice to new members must be applicable to all third-party payers with whom the PCP contracts.

Note 1: The HMO PCP is responsible for arranging for care in his/her absence.

Note 2: The attending physician should be credentialed by Humana.

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

Required for Medicare Providers and Recommended for all other Providers

Covered services must be geographically accessible and consistent with local patterns of care, ensuring that no member residing in the service area must travel an unreasonable distance to obtain covered services. The following services must be available in the plan's service area:

- Medical coverage 24 hours a day, seven days a week
- Urgent but non-emergent appointments within 24 hours, seven (7) days a week
- Urgently needed services must be provided immediately for Medicare members
- Non-urgent, but in-need-of-attention appointments within one week
- Routine and preventive care or well-child appointments within 30 days

In addition Humana Recommends the Following Standards for all Providers:

- Response to urgent calls within 15 minutes; response to routine calls within the same business day
- After hours, response to urgent calls in 15 minutes; non-urgent response in 30 minutes
- Specialty care within 21 business days
- In the case of an unexpected emergency, which may cause this standard to be exceeded, the member should be promptly notified and given the option of waiting or rescheduling

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

By monitoring compliance with these guidelines over time, Humana can take action to improve member service availability and access to medical services when necessary. Humana may monitor compliance with the following access standards through a variety of ways including audits during site surveys, telephone audits, member surveys and complaints.

HMO Member/Enrollee Transfers: The following guidelines apply to the transfer of a Humana member upon his/her request from one primary care office to another:

- The member's decision to transfer should be strictly voluntary.
- The member or the legal guardian requesting a change in the primary care office may do one of the following:
 - Sign an Enrollment Change Form or a membership Change Authorization Form.
 - Contact Humana's Customer Service.
 - Call the phone number on the back of the member ID card to arrange the transfer.
- The member must not have been directly recruited by telephone or in person by anyone involved with either primary care office.
- The member must not have been influenced to transfer offices due to improper or incorrect information, or for medical reasons.
- Upon a member's request, the primary care office must send his/her medical records to the newly selected primary care office.

Humana may review the transfer and, if any of the above guidelines have been violated, a transfer in primary care offices will not be approved

HMO PCP Transfer of Member/Enrollee: If a PCP wants to transfer a member with his/her power of attorney/guardian to another PCP, the PCP must prepare a Physician Initiated Transfer Request Member Notice and forward it with supporting documentation to the local Humana market medical director or market president. The form may be obtained through the local Humana market office. The PCP will be notified of the approval/denial decision. **PCPs may not coerce a member to transfer.**

Any primary care office that violates guidelines for transferring members to another office is given a 30-day, noncompliance written notification requiring immediate corrective action. If the primary care office is found in violation of established policies and procedures and is, therefore, considered to be noncompliant, a termination letter including appeals rights will be sent. Members or their power of attorneys/guardians have the right to file a grievance if the transfer is approved.

Disenrollment Outside of the Service Area: A member must notify a customer service representative when he/she permanently moves out of the service area. A permanent move is an absence of more than six months.

Medicare Advantage Members: If a plan offers a continuation area, permanent out-of-area Medicare Advantage members will receive benefits in the continuation area. The primary care office must:

- a. Obtain documented acceptable evidence indicating the member has permanently moved out of the service area. Acceptable evidence includes:
 - Certified return-receipt letters, indicating an absence of more than six months.
 - Conversation documented and witnessed when a member admits to a permanent absence from the service area, but does not voluntarily choose to disenroll.
 - Medical records, which indicate an absence of more than six months from the service area.
- b. Complete a Request to disenroll form (available from the local Humana market office or by calling Provider

Relations at 1-800-626-2741) and attach any supporting documentation regarding the member's move outside the service area.

c. Send the form and documentation to the following address:

Humana

Attention: Out of Service Area
Medicare Enrollment Department
P.O. Box 14168
Lexington, KY 40512

Medicare enrollment reviews the request and supporting documentation. If there is sufficient evidence indicating the member has left the service area, the documentation is submitted to CMS. A letter is sent to the member from the Medicare retention unit to advise him/her of the effective disenrollment date and to give the member an opportunity to request a reconsideration if he/she disagrees with the decision. If the member does not respond within six months from the date of the letter, member will be disenrolled.

If Medicare enrollment does not agree with the primary care office's request for disenrollment, the office may be asked to gather additional information in support of its case and to resubmit the request.

Preferred Provider Organization (PPO)

Under a commercial PPO plan, members may use the provider of their choice, regardless of whether the provider participates in the PPO network. However, when participating providers are used, members have a higher level of coverage.

Medicare Advantage PPO plans require that members use a provider who is eligible to participate in Medicare, except in emergent/urgent situations. Some Medicare Advantage PPO plans require or request members to name a primary physician.

XII. Credentialing

Credentialing refers to a process performed by Humana to verify and confirm that an applicant (physician and/or other provider type) meets the established policy standards and qualifications for consideration in a Humana provider network. Upon completion of the credentialing process, each applicant is presented to the Credentials Committee which is comprised of physicians in various specialties for review and recommendation. Initial credentialing is performed when an application is received and recredentialing is conducted at least every three years thereafter, or as otherwise required by state regulations and at the discretion of the health plan.

There is required supporting documentation that must be submitted with each credentialing application. Such documentation may include, but is not limited to, licensure, education, training, clinical privileges, work history, accreditation, certifications, professional liability insurance, malpractice history, professional competency and any physical or mental impairments. Documentation submitted by an applicant and/or provider's office is verified for accuracy and completeness. At the discretion of Humana, an applicant may be required to submit additional information.

Humana recognizes a provider's right to review information submitted in support of his/her credentialing application to the extent permitted by law and to correct erroneous information. At any time during the credentialing process a provider may request the status of his/her application by contacting the Humana Credentialing Department. The fact that a provider is credentialed is not intended as a guarantee or promise of any particular level of care or service.

Council for Affordable Quality Healthcare: Humana is a member of the Council for Affordable Quality Healthcare (CAQH). CAQH is an online single entry national database that eliminates the need for providers to complete and submit

multiple credentialing applications. Physicians and other healthcare providers who are members of CAQH are able to submit an initial credentialing application to Humana or provide the required information at recredentialing rather than completing credentialing applications. Additional information is available by contacting the Humana Credentialing Department. Please note the aforementioned information is relative to participating providers only. Nonparticipating providers interested in joining our network should use our online contracting form (<http://www.humana.com/providers/network/>).

Humana Credentials Committee: The Humana Credentials Committee is composed of a chairperson and Humana's employed and participating providers. Functions of the committee include credentialing, ongoing and periodic assessment of current policies/procedures, recredentialing and the establishment of policies and procedures based on current guidelines and regulations.

Providers seeking network participation or recredentialing are presented to the Humana Credentials Committee for review and a recommendation. The committee will render a recommendation to approve or deny network participation. The provider will be notified of the committee's decision. If approved, an agreement is executed by the provider and Humana.

Recredentialing: The process of recredentialing is conducted at least every three years in accordance with Humana's Recredentialing Policy or as otherwise required by state regulations and at the discretion of the health plan.

XIII. Quality Management

Quality Management

Upon request, Humana will make available to providers information about its quality management and quality improvement program and a summary report on Humana's progress in meeting quality improvement goals. To obtain a copy, call the local Humana market office's Quality Management Department or call Provider Relations at 1-800-626-2741.

Quality Management Activities: Participating providers agree to allow and assist Humana with its performance of the following quality management activities:

- **Medical Records Reviews** – Conducted to meet requirements of accrediting agencies and federal and state law requirements. Annually, Humana may review a sample of clinical records for Humana members. Humana does not review all records and is not responsible for assuring the adequacy or completeness of records.
- **HEDIS®** – Healthcare Effectiveness Data and Information Set (HEDIS) is a set of performance measures. Humana may conduct medical record reviews to identify gaps in care for Humana members. HEDIS now includes care coordination measures for members transitioning from a hospital or emergency department to home for which hospitals and providers have additional responsibilities. In addition to medical record reviews, information for HEDIS is gathered administratively via claims, encounters and submitted supplemental data. There are two primary routes for supplemental data, nonstandard and standard.
- Nonstandard supplemental data involves directly submitting scanned images (e.g. .pdf documents) of completed attestation forms and medical records. Nonstandard data also can be accepted electronically via a proprietary Electronic Attestation Forms (EAF) or Practitioner Assessment Forms (PAF). Nonstandard supplemental data is subject to audit by a team of nurse reviewers prior to closing HEDIS opportunities.
- Standard supplemental data flows directly from one electronic database (e.g. population health system, EMR) to another without manual interpretation. Therefore, standard supplemental data is exempt from audit consideration. Standard supplemental data can be accepted via HEDIS-Specific custom reports extracted directly from the provider's EMR or population health tool and is submitted to Humana via either secure email or FTP transmission. We also accept lab data files in the same way. Humana partners with various EMRs to provide member summaries and detail reports and to automatically retrieve scanned charts.

- **CAHPS®** – The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey includes several measures that reflect member satisfaction with the care and service provided by the physician.
- **HOS** – The Health Outcomes Survey (HOS) includes several measures that reflect member’s self-reported health perception, member’s discussion with practitioner and member’s report of receiving treatment from practitioner. Health plans use the data from HOS for quality improvement activities. CMS also uses this report to judge a health plan’s ability to maintain or improve the physical and mental health of its members, provide health plan accountability and publicly report outcomes.
- Humana is rated on an annual basis by the government on multiple measures that fall under HEDIS, CAHPS and HOS. Each year surveys are sent to our members that ask multiple questions of how you, the physician, and Humana are performing. It is imperative that we partner to strive for excellence in these areas. For further information, please visit <http://www.cms.gov>
- **Occurrences and Adverse Events Reporting** – Unexpected occurrences and adverse events involving members are reported to the Quality Management Department by providers, precertification nurses and case managers. Cases are reviewed according to Humana’s Quality Management and, as applicable, peer-review process, as required by law and accrediting agencies.
- **CMS Quality Improvement Organization (QIO)** – QIO oversees the Medicare Advantage Prescription Drug (MAPD) plans and collaborates with the plan for Quality Improvement activities.
- **Member Complaints** – Member complaints and grievances pertaining to quality-of-care and concerns may be referred to the Quality Management Department for review.
- **Medicare Advantage (MA) Organizations Must Comply with the Following Requirements:**
 - Maintain a health information system that collects, integrates, analyzes and reports data necessary to implement the quality improvement program.
 - Have a Chronic Care Improvement Program (CCIP) that identifies enrollees with multiple or severe chronic conditions, who meet the criteria for participation and a mechanism for monitoring enrollee participation in the program. The CCIP currently focuses on effective management of members who have COPD (chronic obstructive pulmonary disease).
 - Initiate quality improvement projects (QIP) that address those areas that have been identified as healthcare priorities for MA beneficiaries, or topics that are mandated by CMS or other regulatory bodies. The QIP currently focuses on improving the HEDIS measure around follow-up after emergency department visits for people with high-risk multiple chronic conditions (FMC).

XIV. Population Health Management

Population Health Management

Disease Management and Case Management Programs: Humana offers several disease/condition-specific programs designed to provide the member with education and support. The programs are offered at no cost to members by Humana and may be offered through approved outside vendors.

Disease Management (DM) Program: Humana offers several disease-specific programs to provide additional support to members and their physicians. These programs are designed to complement the physician’s treatment plan and empower the member through education and support. Members identified by the provider as being candidates for any of the DM programs may be referred by the provider to the disease management manager by contacting the local Humana market office or providers may refer members to the DM program directly via the contact information on Humana’s website.

Case Management Programs

Complex Case Management (CCM) is provided by Humana nurses specially trained in case management. Their specialized focus is on members with complex medical situations or those who have been hospitalized. Management varies by the individual and may include on-site nurse or telephonic support, discharge follow-up support, coordination of services and integrated behavioral health assessment. To refer **commercial** members, call 1-800-327-9496.

Medicare and **Medicaid** members may be referred to CCM and DM programs by calling the Health Services Line at 1-800-322-2758.

Additionally, on behalf of the member, providers may call a Humana Health Planning and Support nurse at 1-800-491-4164 to screen members for clinical programs. Members in all lines of business, except PDP, are eligible. Nurses are available Monday–Friday, 8:30 a.m. to 5 p.m. in your time zone.

Information about Humana’s Health and Wellness, Disease Management and Case Management programs and how to refer members to the programs are found on [Humana.com](https://www.humana.com), providers’ section.

Humana At Home (HAH) is a Humana Inc. source for providing care management services to Medicare Advantage members identified as having complex challenges including multiple acute and chronic conditions, physical and behavioral health compromises, multiple co-morbidities, frailty, disability; as well as cognitive, social, end-of-life issues, isolation, depression, poly-pharmacy challenges and financial issues. Services are delivered telephonically and/or in person. Practitioners and providers may make referrals by calling the HAH Care Center at 1-800-662-9508 during regular business hours or by calling the number on the back of the Humana member’s ID card.

Personal Nurse: Humana’s Personal Nurse® (PN) service is a telephonic outreach program that may be available to commercial members. The PN program is intended to provide members with information they can use in discussing their care with their providers. Personal nurses develop relationships to engage and empower members to make lifestyle behavior changes to better manage their health conditions. These nurses receive special training in behavioral theory to engage, coach and motivate members to make positive lifestyle choices. The service is designed to help members become more educated and actively involved in decision making about their health. Personal nurses promote changing behavior, rather than just managing symptoms, which is the key to improving members’ lives and reducing healthcare costs. To refer a member, call 1-877-416-8773, or encourage the patient to call and request a personal nurse.

Integrated Care Management: Integrated Care Management (ICM) is a new telephonic clinical program provided by a collaborative team of both nurses and behavioral health clinicians who support commercial members with a holistic care approach. This program is for those members with complex physical and behavioral health needs.

ICM partners with members to:

- Further holistic care – assessing the interaction of both physical and behavioral health needs
- Collaborate with the member’s providers and the member’s support network
- Address gaps in care
- Find resources and providers for all of their health needs
- Assist in transitions and planning from different levels of care
- Educate on symptoms and coping skills

Case Management/Chronic Care Management: Humana’s case management team works with members after a hospitalization or procedure, providing discharge support to reduce the risk of readmission. Humana’s chronic care management programs provide member support for many health conditions that include, but are not limited to:

Go365™, an incentive-based wellness program, empowers people with the tools necessary to reach their optimal health. By participating in health-related activities that can be tracked and measured, such as taking wellness classes, exercising and getting regular medical check-ups and screenings, commercial members earn points which are used to determine their Status. Members (except for H1 CAS members) also earn a Buck for every point earned, which they

can redeem for products, services and discounts with our preferred partners. Go365 is available to **commercial** (fully insured, administrative-services only (ASO) (self-funded) and **Medicare** MA/MAPD and group.

HumanaBeginnings®: Humana’s maternity management program may be available to **commercial** fully insured members, select ASO groups, Illinois duals and **Medicare** members. HumanaBeginnings (HB) provides a maternity program with prenatal services to eligible members through telephonic outreach regardless of gestational age at time of enrollment. The primary focus, telephonically, is moderate-to-high-risk members; however, low-risk members and catastrophic cases may participate in the letter campaign portion of the program. The HB Maternity Program provides pregnant members with education, guidance and support to increase their understanding of healthcare options, risk factors, lifestyle changes and enhance their ability to better manage their pregnancies and babies’ health for best possible outcome through telephonic support from registered nurses licensed in the state in which the member resides.

To refer a member, call 1-888-847-9960, email HumanaBeginnings@humana.com, or encourage the patient to call and request a HumanaBeginnings nurse.

Humana Cancer Program:

The Humana Cancer Program provides support and educational services for adults with biopsy-proven cancer who:

- Have begun or are planning to undergo surgery, chemotherapy, radiation or biologic therapy
- Have a history of cancer that has recurred and needs active cancer treatment

The program includes:

- Educating the member about the disease and its medical management
- Reinforcing the importance of the treating physician’s prescribed plan of care
- Addressing side effects of therapy to increase the member’s comfort
- Attempting to avoid hospitalizations
- Monitoring compliance with medications
- Helping transition from active treatment to recovery
- Supporting informed end-of-life decisions, when appropriate
- Co-management with any other clinical program as necessary

To refer a member, call 1-877-416-8773, email cancerprogram@humana.com, or encourage the patient to call and request a cancer nurse.

Humana Chronic Condition Program Includes

- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)

HumanaFirst®: This nurse triage and health-planning service may be available to **Medicare** and **commercial** members. It is available 24 hours a day, seven days a week. Members can talk to a nurse about any immediate medical concerns or to obtain health planning and support. Call **1-800-622-9529**, select “Nurse Advice” and “Immediate Medical Concern.” **Assistance is available 24 hours a day, seven days a week.**

MomsFirst: The MomsFirst OB Case Management Program is responsible for management of **Medicaid** members from pregnancy through the 42nd post-partum day. Case managers assess, evaluate and, in conjunction with the member and physicians, provide care coordination. They collaborate with Healthy Start, WIC and other internal/external programs and facilitate provision of Healthy Behaviors Reward/Incentive for program participation and visit compliance. To refer a patient, contact sfloglobal@humana.com.

Neonatal Intensive Care Program: Provides utilization management and discharge planning services, initiated within one business day of referral, for all newborns not at a normal newborn nursery-level of care.

- Post discharge case management and follow-up with the parents/ guardians are provided for 30 days after hospitalization.
- Resumes inpatient management for program participants who are readmitted within 30 days after a prior hospital discharge for treatment of a condition similar to that of the initial hospitalization.
- High-risk cases may be followed as part of the NICU Grad program for up to the first year of life.

To refer a member, call 1-855-391-8655, option 1, or email: NICU@humana.com.

Renal Disease Program (Medicare/Commercial): Renal care from Village Health is a telephonic program that includes education, coordination of PCP, nephrologists and/or other specialists, conducted by nephrology nurses who coordinate all aspects of patient care for hemo/peritoneal dialysis.

To refer a member, call 1-800-767-0063.

Senior Case Management Program (Medicare): SCM is for members who have chronic diseases, acute health concerns, and need in-depth education. The overall goal is to reduce readmissions.

Potential reasons for referrals to SCM are based on the investigator's clinical knowledge of the case and member's potential need for care coordination.

Reasons for a referral may include:

- Critical event or diagnosis that requires extensive use of resources and assistance navigating the health-care-delivery system
- Chronic condition or multiple co-morbidities with high risk of frequent utilization
- Acute situation that has a potential to become chronic
- New diagnosis with teaching/coaching opportunities
- Interdisciplinary coordination needs
- Coordination of services and resources for compliance with discharge plan
- Multiple drug therapies (e.g., oxycodone, hydrocodone, morphine all being prescribed to treat back pain)
- Visiting multiple emergency rooms daily (e.g., for headaches)
- Community resource needs: e.g., lack of caregiver or support and/or lack of funds to buy food, medications, housing, etc.

Call 1-800-322-2758 to refer a member.

Transplant Management: Transplant Management is a specialty case management team consisting of transplant-experienced clinical advisers and transplant specialists. The transplant clinical team provides benefit guidance, direction to National Transplant Network (NTN) facilities and education to members involved in transplant care for all solid organ, bone marrow transplants, ventricular assist devices (VAD) and/or chimeric antigen receptor (CAR-T) procedure. The members supported by the transplant clinical team face overwhelming physical, emotional and financial challenges. The transplant clinical team assists the member to maximize his or her benefits, simultaneously directing the member to an NTN provider who can best meet the member's needs. The transplant clinical team serves as a single point of contact to providers throughout the pre- and post-transplant/VAD/CAR-T process.

You can refer by contacting the transplant team

- Transplant Management, 1-866-421-5663
- Fax: 502-508-9300

- Email: Transplant@humana.com

Note: Availability of case management outreach for these conditions varies by Humana market and/or line of business.

Humana identifies members who may be eligible for specific disease management programs. Members who are identified by the provider in the inpatient or outpatient setting as being candidates for any of the disease management programs may contact Humana Customer Service for information on Humana's chronic care management programs. Please note the chronic care management or case management referral process above.

XV. Humana EAP and Work-life Services

HUMANA Employee-assistance Program (EAP) and Work-life Services

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

Harris, Rothenberg International Inc., dba Humana EAP and Work-life Services, and its subsidiary, provide a full range of EAP services to client organizations, their employees and beneficiaries.

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

Contact us

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

Clinical services

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

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

Claims procedures

Humana does not reimburse for EAP appointments that were canceled by the member or those where the member failed to show for an appointment. Providers agree not to charge a member for missed sessions. EAP claims must be submitted on a Case Information Update Form (CIUF) on either the EAP Billing Form (included in the authorization notification packet) or a CMS 1500, form within 90 days of the final EAP session to ensure prompt payment and avoid claim denial. The explanation of payment (EOP) or remittance advice will be mailed separately from any payment for claims once the claim is processed.

EAP claims and claims reconsiderations should be mailed to:

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

Or faxed to 1-866-331-5673

Note: Online billing is not available for EAP claims.

XVI. Rights and Responsibilities

Physicians'/Providers' Rights and Responsibilities

To comply with the requirements of accrediting and regulatory agencies, Humana has adopted certain responsibilities for participating providers (commercial, Medicare and Medicaid) that are summarized below. This is not a comprehensive, all-inclusive list. Additional responsibilities are presented elsewhere in this manual and the agreement. Physician/Providers must:

- Have a professional degree and a current, unrestricted license to practice medicine in the state in which provider's services are regularly performed.
- Provider agrees to comply with Humana's quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by Humana
- Be credentialed by Humana and meet all credentialing and recredentialing criteria as required
- MA providers must not be on the CMS preclusion list.
- Provide documentation on their experience, background, training, ability, malpractice claims history, disciplinary actions or sanctions, and physical and mental health status for credentialing purposes.
- Possess a current, unrestricted Drug Enforcement Administration (DEA) certificate, if applicable and/ or a state Controlled Dangerous Substance (CDS) certificate or license, if applicable.
- Have a current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.
- Be a medical staff member in good standing with a participating network hospital(s) if he/she makes plan member rounds and have no record of hospital privileges having been reduced, denied or limited, or if so, provide an explanation that is acceptable to the plan.
- Inform Humana in writing within 24 hours of any revocation or suspension of his/her Bureau of Narcotics and Dangerous Drugs number and/or of suspension, limitation or revocation of his/her license, reduction and/or denial of hospital privileges, certification, CLIA certificate or other legal credential authorizing him/her to practice in any state in which the provider is licensed.
- **Inform Humana immediately** of changes in licensure status, tax identification numbers, NPI, telephone numbers, addresses, status at participating hospitals, provider status (additions or deletions from provider practice), loss or decrease in amounts of liability insurance below the required limits and any other change which would affect his/her participation status with Humana.
- Not discriminate against members as a result of their participation as members, their source of payment, age, race, color, national origin, religion, sex, sexual preference, health status or disability

- Not discriminate in any manner between Humana members and non-Humana members
- Inform members regarding follow-up care or provide training in self-care
- Assure the availability of physician services to members 24 hours a day, seven days a week (required for HMO PCPs and all MA providers)
- Arrange for on-call and after-hours coverage by a participating and credentialed Humana physician (required for HMO PCPs and all MA providers)
- Refer Humana members with problems outside of the physician's normal scope of practice for consultation and/ or care to appropriate specialists contracted with Humana on a timely basis, except when participating providers are not reasonably available or in an emergency.
- Refer members only to participating providers, except when participating providers are not reasonably available or in an emergency.
- Admit members only to participating network hospitals, SNFs and other facilities and work with hospital-based physicians at participating hospitals or facilities in cases of need for acute hospital care, except when participating providers or facilities are not reasonably available or in an emergency.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Humana member, subscriber, or enrollee other than for copayments, deductibles, coinsurance, other fees that are the member's responsibility under the terms of their benefit plan, or fees for non-covered services furnished on a fee-for-service basis. Non-covered services are services not covered by Medicare, or services excluded in the member's plan.
- Provide services in a culturally competent manner, (i.e., removing all language barriers, arranging and paying for interpretation services for limited English proficient [LEP] and the hearing/visually impaired) as required by state and federal law. Care and services should accommodate the special needs of ethnic, cultural and social circumstances of the patient. Additional information and resources are made available by the U.S. Department of Health and Human Services, Office of Minority Health (e.g., <http://minorityhealth.hhs.gov> and <https://www.thinkculturalhealth.hhs.gov/>).
- Provide access to healthcare benefits for all plan members in a manner consistent with CMS requirements for any Humana Medicare Advantage members.
- For Medicare Advantage members who have end-stage renal disease (ESRD), complete Chronic Renal Disease Medical Evidence Report, which is provided by the Social Security office when provider becomes aware of the disease. The form must be completed and returned to the Social Security office and the ESRD Network. Mail or fax the form to:

Humana
 Attn: Medicare Reconciliation Department – ESRD Unit
 Waterside Building
 101 E. Main St.
 Louisville, KY 40202
 Or fax to 502-508-3450
- Provide or arrange for continued treatment to all members including, but not limited to, medication therapy, upon expiration or termination of the agreement.
- Help guarantee accessibility of services to members by maintaining a ratio of members to full-time equivalent (FTE) physicians as follows:
 - One physician FTE to 2,400 commercial and Medicare Advantage member equivalents (CMMEs). An MA member counts as three member equivalents; a commercial member counts as one member equivalent
 - A non-physician practitioner (PA, ARNP, etc.) counts as .5 physician FTE for MA and commercial members
 - One physician FTE for 1,500 Medicaid members

- A non-physician practitioner (PA, ARNP, etc.) counts as .33 physician FTE for Medicaid and may serve no more than 500 Medicaid members

Note: Full-time equivalents may vary by markets. Contact the local Humana market office or call Provider Relations at 1-800-626-2741.

- Retain all agreements, books, documents, papers and medical records related to the provision of services to members as required by state and federal laws and in accordance with relevant Humana policies.
- Treat all member records and information confidentially and not release such information without the written consent of the member, except as indicated herein, or as allowed by state and federal law, including HIPAA regulations.
- Upon request of Humana, provide an electronic automated means, at no cost, for Humana and all Humana affiliated vendors acting on behalf of Humana, to access member clinical information including, but not limited to, medical records, for all payer responsibilities including, but not limited to case management, utilization management, claims review and audit and claims adjudication.
- Transfer copies of medical records for the purpose of continuity of care to other Humana providers upon request and at no charge to Humana, the member or the requesting party, unless otherwise agreed upon.
- Provide copies of, access to and the opportunity for Humana or its designee to examine the provider's office books, records and operations of any related organization or entity involving transactions related to health services provided to members. A related organization or entity is defined as having:
 - Influence, ownership, or control and:
 - Either a financial relationship or a relationship for rendering services to the primary care office.
The purpose of this access is to help guarantee compliance with all financial, operational, quality assurance: peer review obligations, as well as any other provider obligations stated in the agreement or in this manual. Failure by any person or entity involved, including the provider, to comply with any requests for access within 10 business days of receipt of notification, will be considered a breach of contract. For records related to Humana MA enrollees, this access right is for the time stipulated in the agreement or the time period since the last audit, whichever is greater.
- To the extent applicable to the physician, assume full responsibility to the extent of the law when supervising/ sponsoring, whether through a protocol, collaborative, or some other type of agreement, physician assistants (PAs) advanced practice registered nurses (APRNs), nurse practitioners (NPs) and all other healthcare professionals required to be supervised or sponsored, whether through a protocol, collaborative, or some other type of agreement under applicable federal and state law in order to treat members..
- Submit a report of an encounter for each visit when the member is seen by the provider, if the member receives a HEDIS service. Encounters should be submitted electronically or recorded on a CMS-1500 Claim Form and submitted according to the time frame listed in the agreement.
- Meet the requirements of all applicable state and federal laws and regulations including, Section 1557 of the Affordable Care Act, 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.
- Physician's performance of services under the agreement shall be consistent and in compliance with Humana's contractual obligations under its Medicare Advantage contract(s). Physician agrees to cooperate with and assist Humana in its efforts to comply with its Medicare Advantage contract(s) and/or Medicare Advantage rules and regulations and to assist Humana in complying with corrective action plans necessary for Humana to comply with such rules and regulations.
- Submit complete member referral information when applicable and in a timely manner to Humana via electronic means or telephone.
- Notify Humana of scheduled surgeries/procedures requiring inpatient hospitalization.
- Notify Humana of any material change in provider's performance of delegated functions, if applicable.

- Notify Humana of his/her termination 60 days prior to the effective date of termination.
- Not be excluded from participating in Medicare.
- Cooperate with an independent review organization's activities pertaining to the provision of services for commercial members, Medicare enrollees in an MA plan and Medicaid members. Respond expeditiously to Humana's requests for medical records or any other documents in order to comply with regulatory requirements and to provide any additional information about a case in which a member has filed a grievance or appeal.
- Abide by the rules and regulations and all other lawful standards and policies of the Humana plan(s) with which the provider is contracted, including Humana's.
- Ethics Every Day for Contracted Healthcare Providers and Business Partners.
- Understand and agree that nothing contained in the agreement or this manual is intended to interfere with or hinder communications between providers and members regarding a member's medical condition or available treatment options or to dictate medical judgment.
- For those providers who participate in MA networks and who participate in Original Medicare, that they abide by the guidelines set out in Humana's Rules of Participation for MA Networks, which are available on Humana.com, within the Provider Self-service section, under Resources. A paper copy may be obtained upon request.
- Providers, who have downstream agreement(s) with physicians or other providers who provide services to Humana members, agree to provide a copy of said agreement(s) to Humana upon request (financial information will not be requested).
- Abide by all state and federal laws regarding confidentiality, privacy and disclosure of medical records or other health and enrollment information.
- Provider agrees to submit a claim on behalf of the member in accordance with timely filing laws, rules, regulations and policies.
- Provider agrees to pay court costs and/or legal fees incurred by Humana or the member to enforce the terms of this provision.
- Providers understand and agree that provider performance data can be used by Humana.
- Humana prohibits providers from requiring members to select and pay for any type of "concierge medicine" program in order to receive services, items and/or benefits covered by the applicable Humana plan from the provider. Humana considers concierge medicine programs to include any practice management model under which a provider charges each patient a monthly, annual or other periodic fee in exchange for enhanced practice services over and above those services that are covered under the member's health benefit plan, or charges such a fee before agreeing to provide any medical services to a patient.

A provider may offer a concierge medicine program to members, provided that any such program meets the following requirements:

- The provider accepts Humana's reimbursement as payment in full for all services that are covered services under the member's health benefit plan and the provider is prohibited from holding plan members liable for the payment of such services, except for member cost-sharing authorized under the plan.
- Any fees paid by members for the provider's concierge medicine program cannot be in exchange for services that are covered services under the member's health benefit plan.
- The provider must be accessible and available to members consistent with Humana's participating provider requirements including, but not limited to, those requirements outlined in this manual, the provider's participation agreement with Humana and those requirements outlined by any applicable state or federal law, including but not limited to those requirements outlined by the Centers for Medicare & Medicaid Services under the Medicare Managed Care Manual MMCM, Ch. 4, Section 110.1.1, regardless of whether a member chooses to participate in the provider's concierge medicine program. The provider shall ensure that quality of care will not

be adversely impacted if a member chooses not to participate in the provider's concierge medicine program.

- The provider is prohibited from offering its concierge medicine program in any way that discriminates against members.
- A member's choice to participate in a provider's concierge Medicine program must be entirely voluntary. The provider is prohibited from inappropriately coercing or pressuring the member to participate in a concierge medicine program.
- Any concierge medicine program agreement with a member must: (a) inform the member that the program is optional and that he or she does not have to select and pay for the program in order to receive healthcare services from the provider that are covered services under the member's health benefit plan; (b) list the fee or fees and the added services, items and/or benefits included in the program; and (c) inform the member that the selection of and payment for the program is solely for services, items and/or benefits in addition to services that are covered services under the member's health benefit plan.
- The provider must provide a copy of its concierge medicine program agreement with members and any related materials to Humana immediately upon request.
- The concierge medicine program does not otherwise conflict with the terms of the provider's participation with Humana, including, but not limited to, those terms and/or requirements outlined in this manual, the provider's participation agreement with Humana and any applicable state or federal law, including but not limited to those requirements outlined by the Centers for Medicare & Medicaid Services.

Members' Rights and Responsibilities

Humana adheres to certain rules of accrediting and regulatory agencies concerning member rights. Humana members have certain rights and responsibilities when being treated by Humana-contracted providers. The rights and responsibilities statement below, though not intended to be exhaustive, reminds members and providers of their complementary roles in maintaining a productive relationship.

Humana members have the right to:

- Be provided with information about their plan, its services and benefits, its providers and the rights and responsibilities of members.
- Choose a primary care provider from our network of affiliated providers and to change to another primary care provider in the Humana network.
- Discuss their medical record with their physician and receive, upon request, a copy of that record.
- To participate with providers in making decisions about their healthcare.
- Have a candid discussion with their provider about appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Expect reasonable access to medically necessary healthcare services, regardless of gender, race, national origin, religion, physical abilities or source payment.
- File a formal complaint, as outlined in the plan's grievance procedure and expect a response to that complaint within a reasonable period of time.
- Be treated with courtesy and respect, with appreciation for their dignity and protection of their right to privacy.
- Make recommendations regarding the plan's "rights and responsibilities" policies.
- Expect Humana to adhere to all privacy and confidentiality policies and procedures.
- Have an initial health risk assessment conducted for care for MA members within the first 90 days of enrollment.

- MA members have direct access to a woman's health specialist, within the network, for routine and preventive health services, such as mammography screening and influenza vaccinations that are provided as basic benefits for women.
- MA members have direct access to influenza vaccinations for routine and preventive health services provided as basic benefits. Certain preventive health services, such as influenza and pneumococcal vaccines, do not require a copayment.
- Receive services that are provided in a culturally competent manner.
- Receive treatment for any emergency medical condition.
- Select an in-network provider and not be balance billed for medically necessary covered services.
- Receive an EOB and discuss that EOB with the plan.
- Members have the right to file a claim or have a claim filed by a provider on their behalf.
- MA members who have a disagreement with his/her physician about a denial of service have the right to request and receive an organization determination from the plan regarding the services or treatment being requested.

Humana members have the responsibility to:

- Give the plan and their healthcare provider complete and accurate information needed for their care.
- Read and be aware of all material distributed by the plan explaining policies and procedures regarding services and benefits.
- Obtain and carefully consider all information they may need or desire to give informed consent for a procedure or treatment.
- Be considerate and cooperative in dealing with the plan providers and respect the rights of fellow members.
- Schedule appointments, arrive on time for scheduled visits and notify their healthcare provider if they must cancel or be late for a scheduled appointment.
- Express opinions, concerns or complaints in a constructive manner.
- Inform Humana of any change in their contact information, such as address or phone number, even if these changes are only temporary.
- Pay all premiums and applicable copayments, coinsurance and deductible amounts by the due date.
- Follow healthcare facility rules and regulations affecting patient care and conduct.
- Carry their Humana identification card with them at all times and use it while enrolled in the plan.
- Follow the plans and instructions for care that they have agreed upon with their providers.

Note: In some states, providers are required by law to post members' rights and responsibilities. To be in compliance with CMS' member's rights and responsibilities, Humana has a process in place for both current and prospective beneficiaries to exercise choice in obtaining Medicare services.

Advance Directives: The Patient Self-Determination Act of 1990 and state law provides every adult member the right to make certain decisions concerning medical treatment. Members have the right, under certain conditions, to decide whether to accept or reject medical treatment, including whether to continue medical treatment that would prolong life artificially.

These rights may be communicated by the member through an advance directive. Two kinds of advance directives are generally recognized by law: the living will and the durable power of attorney for healthcare.

The member's primary care office is not required to have living will or durable power of attorney blank forms available. However, the primary care office must have procedures in place to help assure that the existence of completed advance directive forms is conspicuously noted in the member's medical record.

Professional Conduct during Physical Examination of Plan Members: The member or provider may request a chaperone to be present during any office examination. The chaperone may be a family member or friend of the member, or the physician's/provider's assistant. Prior to an examination of a minor, the physician should obtain a parent or guardian's consent in the manner specified by the state.

Note: Some states have regulations that may conflict with these guidelines. In those instances, state regulations, if more stringent, take precedence over the guidelines stated above.

XVII. Accreditation

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

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

HEDIS® is designed to measure plan and provider performance on a number of measures to produce a consumer report card. The information collected from managed care plans is published to assist consumers in choosing a healthcare plan, physicians and other healthcare providers. Specific HEDIS measures may change annually to reflect medical advances and to identify new areas in which to focus improvement efforts.

Humana prepares information for NCQA based on data obtained from participating providers in the form of claims or encounter records. In addition to gathering HEDIS data administratively via claims and encounters, Humana also encourages submission of supplemental data. For example, one HEDIS measure is to determine if members with diabetes receive an annual dilated eye examination. The percent of diabetic members who meet HEDIS criteria and have an encounter reported for a dilated retinal eye examination is reported. If there is no report of such an examination, the member is identified as needing an examination. Members may receive an outreach as a reminder of the importance of the examination, assist in scheduling an appointment, or help overcome their barriers to receiving the examination. The type of outreach the member receives is based upon consumer insights and their past history of completing a dilated eye examination.

Periodically, the health plan Quality Management Department may visit provider offices to review medical records of members and to collect data.

URAC (originally known as Utilization Review Accreditation Commission): A nonprofit organization founded in 1990 to establish standards for the healthcare industry by providing a method of evaluation and accreditation for a variety of healthcare organizations, including health plans, utilization management organizations, pharmacy benefit managers and others. There are more than 20 accreditation and certification programs, some that review the entire organization, such as the health plan standards and some that focus on a single functional area in an organization, e.g., case management or credentialing. Any organization that meets the standards, including hospitals, HMOs, PPOs, TPAs and provider groups, can seek accreditation.

XVIII. Delegation

What is Delegation?

Delegation is the formal process by which one enterprise, such as Humana, grants to another legal entity (delegate) the authority to perform certain functions on its behalf, such as:

- Credentialing of physicians, facilities and other healthcare providers
- Provision of clinical health services such as utilization management, disease management and complex case management
- Claims adjudication and payment
- Inquiries in the medical and managed behavioral healthcare organization (MBHO) setting
- Triage and quality management in certain MBHO settings

A function may be fully or partially delegated. Full delegation allows all activities of a function to be delegated. Partial delegation is the instance in which some of the activities associated with a particular function will to be delegated. For example, partial delegation of Utilization Management might mean that referral management is delegated while Humana retains the Utilization Management of inpatient services for members. The decision of which functions may be considered for delegation is determined by the type of contract a delegate has with Humana/ChoiceCare, as well as the ability of the delegate to perform the function pursuant to Humana's policies and procedures, as well as Accreditation Organization standards and state and federal regulatory requirements and to accept the required oversight of the function by Humana.

Humana does not delegate any aspect of appeal and grievance management except in certain special circumstances.

Although a health plan can delegate the authority to perform a function, it cannot delegate the responsibility or accountability for making sure that the function is performed in an appropriate and compliant manner.

Contact the local Humana market office provider representative for detailed information on delegation, or call Provider Relations at 1-800-626-2741.

Note: Although Humana can delegate the authority to perform a function, it cannot delegate the ultimate responsibility for fulfilling the service or obligation.

Delegated providers must comply with the responsibilities outlined in the Delegated Services, Policies and Procedures, Appendix A, section of this manual. The document is available on [Humana.com](https://www.humana.com), or a copy may also be obtained from the local Humana market office, or by calling 1-800-626-2741.

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State-specific Provisions

If required, state-specific provisions will be included in this section for the applicable state.

Appendix A

Delegated Services, Policies and Procedures

Introduction

The guidelines and responsibilities outlined in this appendix are applicable to all contracted Humana and ChoiceCare® delegated entities (delegate).

The information provided is designed primarily for the delegate's administrative staff responsible for the implementation or administration of certain functions that Humana/ChoiceCare has delegated to an entity.

The policies in Humana's Provider Manual for Physicians, Hospitals and Other Healthcare Providers (manual) also apply to delegated entities. Humana/ChoiceCare also expects any delegate to adhere to accreditation organization standards, federal and state rules, laws and regulations when performing any delegated activity, Humana/ChoiceCare's delegation policies and procedures, as well as their underlying contractual requirements pertaining to the provision of healthcare services.

Oversight

Oversight is the formal process where Humana performs auditing and monitoring of the delegate's:

- Ability to perform the delegated function(s) on an ongoing basis;
- Compliance with accreditation organization standards, state and federal regulatory requirements and Humana/ChoiceCare policies and procedures; and
- Financial soundness (if delegated for claims adjudication and payment).

Humana/ChoiceCare will perform a pre-delegation audit prior to any function being delegated to a prospective entity which will include evaluation of a prospective delegate's compliance and performance capacity. After approval and an executed delegation agreement, Humana will perform an annual audit. These audits will include a review and approval of the following applicable items of the prospective delegate:

- Policies and procedures
- Program descriptions and work plans
- Forms, tools and reports
- Sub-delegation agreements
- Audit of contracted sub-delegate's program including policies, procedures and program documents
- Letters of accreditation
- Financial solvency (claims delegation only)
- File audit
- Federal/state exclusion screenings
- Offshore contracting

Humana/ChoiceCare will continue to monitor all delegated entities through the collection of periodic reporting outlined within the delegation agreement.

Downstream Education

Administrative staff of the delegate bears a responsibility to educate downstream contracted physicians, healthcare providers and employees, as well as any other entity to whom they subcontract activities (which requires preapproval to perform any delegated function from Humana/ChoiceCare), about Humana/ChoiceCare policies and procedures, regulatory requirements and accreditation organization standards. Distribution of compliance policies and procedures and standards of conduct, as well as compliance and fraud, waste and abuse training, as specified in the compliance policy, must occur as required by federal regulations. Additional details about the compliance and fraud, waste and abuse requirements are referenced in the Compliance and Fraud, Waste and Abuse Requirements section of this manual and detailed in the Compliance Policy, Standards of Conduct and Humana's FWA training, all of which are available on Humana's website.

Explanations of any special circumstances, which justify variation from the guidelines set forth in this appendix, should be documented, retained and discussed with the Humana Provider Representative or ChoiceCare Provider Relations prior to implementation. Humana/ChoiceCare expects to periodically review and approve all downstream educational material to confirm that all information mentioned in this appendix is referenced.

The following information should be incorporated into the delegate's business practices as it relates to the functions delegated by Humana/ChoiceCare.

Humana, Legal, Regulatory and Accreditation Requirements

The delegate will comply with the following requirements:

- Make available to Humana/ChoiceCare, its designee or any state or federal governmental agency all documents, including but not limited to logs, files, committee meeting minutes and reports required within the timeframe determined by the auditor.
- Agrees that Humana/ChoiceCare retains the right to approve, modify, suspend, rescind, or terminate at any time any or all delegated activities.
- Submit any material change in the performance of delegated functions to Humana/ChoiceCare for review and approval, prior to the effective date of the proposed changes.
- Notify Humana/ChoiceCare within the next business day of any corrective action plan and/or sanctions, fines or other penalties imposed on or incurred by delegate or if applicable its subcontractor, following any review by a regulatory agency or accreditation organization.
- Delegate will review the Department of Health and Human Services (DHHS) OIG and General Services exclusion lists and the CMS preclusion list prior to hire or contract and monthly thereafter according to federal regulations. If a provider, employee, or downstream entity is on either list, delegate will terminate the provider's participation agreement for Medicare Advantage or Medicaid products immediately and, if applicable, take appropriate corrective actions.
- Comply with the Employee Retirement Income Security Act (ERISA) requirements.
- Comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements.
- If required by state and/or federal law, rule or regulation, will obtain and maintain in good standing, a third-party administrator license/certificate and or a utilization review license or certification.
- Assure that personnel, who carry out the delegated services, have appropriate training, licensure and/ or certification.
- Humana's record retention policy for all delegated function documents is ten (10) years, the same as the CMS requirement.

Delegated Provider Downstream Contract Content

The delegate and when applicable its subcontractors, will make available to Humana/ChoiceCare templates or samples of contracts with physicians and other downstream providers and ensure compliance with the legal and regulatory contractual requirements, including HIPAA regulations. Delegate is not required to make available to Humana/ChoiceCare contractual provisions relating to financial arrangements with delegate's subcontracted physicians and providers.

When requested, the delegate will provide templates of their downstream contracts for auditing purposes. Physician and provider contract content should include, at a minimum for Medicare Advantage contracts, the Medicare Advantage provisions noted in the contract between the delegate and Humana and include the Medicare Advantage Guidelines located in the body of this manual.

In addition, state Medicaid requirements must also be contained, as appropriate, in the downstream contracts.

Participating provider commercial contracts should include, at a minimum, the state-specific requirements attachment.

Note: Health plans, first tier and downstream entities are prohibited from employing or contracting with individuals excluded from participation in federal government programs.

Sub-delegation

- The delegate must have Humana/ChoiceCare's prior written approval for any sub-delegation by the delegate of any functions and/or activities. In addition, note that Humana/ChoiceCare must notify CMS of any location outside of the United States or a United States territory that receives processes, transfers, stores or accesses Medicare beneficiary protected health information in oral, written or electronic form.
- If the delegate, with Humana/ChoiceCare's prior written approval and 90 days prior to the anticipated effective date, subcontracts with another entity (subcontractor) to perform any portion of any delegated function, delegate will demonstrate and provide documentation of oversight of subcontractor by delegate. Humana/ChoiceCare retains the right to perform its own evaluation of the subcontractor prior to approval.
- The delegate will execute a written agreement between delegate and subcontractor which must include the following:
 - Describes all functions and/or activities that are being sub-delegated.
 - The responsibilities to be delegated to the subcontractor and those retained by the delegate.
 - Describes the process by which the delegate will provide oversight of the subcontractor.
 - A requirement that the delegated functions are to be performed in accordance with Humana/ChoiceCare and delegate's requirements, state and federal rules, laws and regulations and accreditation organization standards.
 - The subcontractor must notify the delegate of any material change in the subcontractor's performance of delegated functions.
 - Submission of periodic performance reports as required by Humana/ChoiceCare and the delegate.
 - The subcontractor must have Humana/ChoiceCare's/delegate's prior written approval for any further delegation and those functions will be subject to the terms of the written agreement between the subcontractor and delegate and Humana/ChoiceCare and in accordance with state and federal rules, laws and regulation and accreditation organization standards.
 - The remedies, including revocation of the delegation available to delegate if the subcontractor does not fulfill its obligation.

Delegate is responsible for providing adequate oversight of the subcontractor and any other downstream entities, including oversight of compliance program requirements. Humana/ChoiceCare retains the right to perform additional

evaluation and oversight of the subcontractor, if deemed necessary by Humana/ ChoiceCare. Furthermore, Humana/ ChoiceCare retains the right to modify, rescind, or terminate at any time any one or all delegated activities hereunder, regardless of any sub-delegation that may have been previously approved.

Appeals and Grievances

Humana/ChoiceCare member appeals/grievances and expedited appeals are not delegated, including any appeal made by a physician/provider on behalf of the member. Humana maintains all member rights and responsibility functions except in certain special circumstances.

- Delegate will need to forward member appeals/grievances to Humana/ChoiceCare within one (1) business day.
- Delegate will need to forward all expedited appeals immediately upon notification/receipt.
 - Medicare:
 - Telephone number: 1-800-867-6601
 - Fax number: 1-800-949-2961
 - Medicaid:
 - Telephone number: 1-800-764-7591
 - Fax number: 1-855-336-6220
 - Florida Medicaid:
 - Telephone number: 1-800-477-6931
 - Fax number: 1-855-336-6220
 - Commercial and Exchange:
 - Telephone number: 1-888-259-6767
 - Fax number: 1-920-339-2112
- Delegate will provide the following information in the fax: date and time of receipt, member information, summary of the appeal or grievance, all denial information if applicable and summary of any actions taken if applicable.

Delegate will handle physician, provider, hospital and other healthcare professional and/or participating provider claim payment and denial complaints or claim contestations and provider appeals regarding termination of the agreement. For all non-participating provider appeals for claims payment and denials, please reference your delegation agreement for details.

Corrective Action Plans

Failure of the delegate to adequately perform any of the delegated functions in accordance with Humana/ChoiceCare requirements, federal and state laws, rules and regulations, or accreditation organization standards may result in a written corrective action plan (CAP). The delegate will provide a written response describing how they will meet the requirements found to be noncompliant, including the prospective date of compliance.

Humana/ChoiceCare will cooperate with the delegate or its subcontractors to correct any failure. Any failure by the delegate to comply with their contractual requirements or this manual or any request by Humana/ChoiceCare for the development of a CAP may result, at Humana/ChoiceCare's discretion, in the immediate suspension or revocation of all or any portion of the functions and activities delegated, including withholding a portion of the reimbursement or payment under the contract agreement.

Utilization Management

Delegation of utilization management (UM) is the process by which the delegated entity evaluates the necessity, appropriateness and efficiency of healthcare services to be provided to members. Generally, a review coordinator gathers information about the proposed hospitalization, service, or procedure from the patient and/or provider and then determines whether it meets established guidelines and criteria. Reviews can occur prospectively, concurrently (including urgent/emergent) and/or retrospectively.

Expectations and Guidelines – Global and Full Risk Arrangement/Contracts

Global risk is defined as the participating provider's assumption of 100 percent risk on both Part A (institutional) and Part B (outpatient referrals) funding pools. Full risk is defined as the participating provider's assumption of 50 percent – 99 percent risk on Part A (institutional) funding and 100 percent risk on Part B (outpatient referrals) funding. Some of these guidelines may vary by contract; refer to the Humana/ChoiceCare contract utilization management delegation addendum or amendment and respective attachments for specific details. Failure to adhere to the guidelines may result in the issuance of a CAP by Humana/ ChoiceCare and/or rescission of all or part of the delegated function(s).

The general guidelines that Humana/ChoiceCare requires global and full risk provider groups delegated for UM to adhere to include, but may not be limited to, the following:

UM Activities and Responsibilities – Inpatient and Skilled Nursing Facility (SNF) Management

Delegate is to conduct the following functions regarding initial determination for inpatient and SNF stays:

- Preadmission review and authorization, including medical necessity determinations based on approved criteria, specific benefits and member eligibility. In full-risk arrangements, Humana performs this function when review decisions by delegate are not timely, are contrary to medical necessity criteria and/or when Humana must resolve a disagreement between delegate, providers and member. In some local health plans, Humana may assume total responsibility for this function – refer to the delegation addendum or amendment of the agreement for specifics.
- As required, perform expedited determinations and maintain expedited determinations log; submit log as required by regulatory and accreditation organization standards. In full risk arrangements, Humana performs this function when review decisions by delegate are not timely, are contrary to medical necessity criteria and/or when Humana must resolve a disagreement between delegate, providers and member. In some local health plans, Humana may assume total responsibility for this function.
- Notify member, facility and provider of decision on initial determination. For adverse determinations, maintain denial log and submit as required by regulatory and accreditation organization requirements. Humana retains the right to make the final decision regardless of contract type.

The delegate is to perform the following concurrent review activities relevant to inpatient and SNF stays:

- Conduct on-site or telephonic review for continued stay assessment using approved criteria.
- Identify potential quality of care concerns, including hospital reportable incidents, including, but not limited to, sentinel events and never events and notify the local health plan for review within 24 hours of identification or per contract. Humana/ChoiceCare does not delegate quality of care determinations.
- Make continued stay determinations and maintain denial log for submission to Humana as directed. Humana retains the right to make the final decision in all contract arrangements. Refer to the agreement, delegation addendum or amendment and respective attachments for CMS requirements for Medicare members.
- Notify members or legal guardians of denial determinations using Humana/CMS approved letter.
- Notify physician and facility of denial determinations.

The delegate is to perform discharge planning and retrospective review activities related to inpatient and SNF stays.

UM Activities and Responsibilities – Outpatient Management

The delegate is to conduct the following functions regarding initial determinations as related to ambulatory care:

- Perform, manage and monitor the referral process. Determine the appropriateness of each referral to specialists, therapists, etc., as it relates to medical necessity.
- Monitor ambulatory member services.
- Perform expedited determinations and submit expedited determinations log to Humana as directed.
- Help ensure that all decisions are compliant with mandated benefits and that all regulatory and accreditation organization requirements are met within the established processes.
- Notify provider/facility of determinations
- Notify member, their authorized representative or legal guardian of determinations.

The delegate is to conduct the following functions regarding adverse determinations as related to ambulatory care:

- Perform initial outpatient service/care denials and maintain denial log for submission to Humana as required by regulatory and accreditation organization requirements.
- Maintain documentation of pertinent clinical information gathered to support the denial decision.
- Provide, if directed by Humana, an analysis and summary of compliance to timeliness standards (to include percentage of decisions meeting timeliness standards and, when standards have not been met, the proposed corrective action, including dates for implementation).
- Notify provider/facility of adverse determinations.
- Notify member, their authorized representative or legal guardian of adverse determinations using Humana-approved letter.
- Maintain member denial files, including all supporting documentation, identify potential quality of care concerns and notify Humana within 24 hours of identifying such cases. Humana does not delegate quality-of-care determinations.

The delegate is to conduct retrospective review functions as related to ambulatory care.

Additional UM Activities and Responsibilities

The following are additional expectations of the delegate:

- Denial files and all supporting documentation are Humana's property. Should the contract between the delegate and Humana be dissolved for any reason, the delegate will be expected to make available to Humana either the original or quality copies of all denial files for Humana members.
- Perform UM activities for out-of-service areas and out-of-network providers as dictated by contract.

Expectations and Guidelines – Partial Risk Agreements/Contracts

Partial risk is defined as the participating provider's assumption of some risk, but less than 50 percent risk on Part A (institutional) funding and 100 percent or less risk on Part B (outpatient referrals) funding. Some of these guidelines may vary by contract. Refer to Humana's contract utilization management delegation amendment for specific details. Failure to adhere to the guidelines may result in issuance of a CAP by Humana and/or rescission of all or part of the delegated function. The general guidelines that Humana expects partial risk provider groups delegated for UM to adhere to include, but are not limited to, the following:

- UM outpatient activities and responsibilities.

Note: Humana retains all UM activities related to inpatient and SNF stays.

Complex Case Management (CCM)

Coordination of care and services provided to members who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Disease Management

Disease management (DM) is a multidisciplinary, continuum-based approach to healthcare delivery that proactively identifies populations with, or at risk for, established medical conditions.

Delegate UM, CCM and DM Reporting Responsibilities

Please refer to the reporting tables included in the contract and related addenda or attachments.

Claims Processing

Claims delegation is a formal process by which a health plan gives a participating provider (delegate) the authority to process claims on its behalf. Humana's criterion for defining claims delegation is when the risk provider pays fee-for-service claims. Capitation agreements in which the contractor pays downstream contractors via a capitation distribution formula do not fall under the definition of claims delegation.

The following are general guidelines to which Humana expects entities that are delegated for claims processing to adhere. Failure to adhere to the guidelines may result in issuance of a corrective action plan (CAP) by Humana and/or rescission of all or part of the delegated function.

Claims Performance Requirements

All delegates performing claims processing functions must comply with all state and federal regulatory requirements. In addition, they must conduct claims adjudication and processing in accordance with the member's plan and Humana/ChoiceCare's policies and procedures. Delegate will need to meet, at a minimum, the following claims adjudication and processing performance requirements:

- Delegate must accurately process in a timely manner at least ninety-five percent (95 percent) of the total of all delegated claims according to Humana requirements and in accordance with state and federal laws, rules and regulations and/or any regulatory or accrediting entity to whom Humana is subject, whether voluntarily or not.
- Delegate must pay any and all interest amounts on claims in accordance with applicable state and federal requirements.
- Delegate must maintain an accuracy rate of 99 percent of total dollars paid, for any given calendar month.
- In the event the delegate is responsible for the processing and payment of claims for services rendered to any Humana Medicare Advantage or Medicaid members, delegate must comply with and meet the rules and requirements for the processing of Medicare Advantage or Medicaid claims established or implemented by CMS or the state including, but not limited to, the following:
 - Ninety-five percent of clean claims from nonparticipating providers must be paid within thirty days of receipt. Delegate must pay any CMS or Medicaid mandated interest amounts on all clean claims which are paid to nonparticipating providers later than 30 days from date of receipt.
 - All claims received by delegate must be paid or denied within 60 days of receipt unless state Medicaid requires a different time frame.
 - Humana does not delegate nonparticipating provider reconsideration requests. All such requests are to be forwarded to Humana upon receipt. Refer to Medicare Managed Care Manual, Chapter 13, Section 40.2.3 and/or state and Medicaid rules for additional requirements.
- Delegate must meet CMS and/or state requirements to which Humana is subject for denial and appeals language in all communications made to members and use only language reviewed and approved by Humana.

- Delegate must provide claims processing results on a monthly basis as required by Humana's Delegation Compliance Department using the submission form supplied by Humana.

Humana retains the right and final authority to pay any claims for its members regardless of any delegation of such functions or activities to delegate. Amounts authorized for payment by Humana of such claims may be charged against delegate's funding. Refer to contract for funding arrangement details.

Delegate shall provide a financial guarantee, acceptable to Humana prior to implementation of any delegation of claims processing, such as a letter of credit to ensure its continued financial solvency and ability to adjudicate and process claims.

Systems, Records and Communication

The delegate must:

- Supply staff and systems required to receive eligibility and benefit information from Humana and provide claims and encounter data to Humana as required by state and federal rules, regulations and Humana.
- Supply and maintain claims processing systems that meet current legal, professional and regulatory requirements.
- Print delegate's name and logo on member explanations of benefits (EOBs) forms, letters and other documents related to adjudication or adjustment of member benefits and medical claims.
- Retain and maintain legal, claims and encounter documents for the period of time and in the manner required by state and federal law or Humana, including without limitation HIPAA and/or any requirements of regulatory or accreditation organization to which Humana is subject, whether voluntarily or not.
- Make available as requested by Humana all original files, records and documentation pertaining to Humana enrollees, or copies thereof upon the termination of the performance of delegated functions and/or the expiration, nonrenewal or termination of the agreement, regardless of the cause.
- Submit claim/encounter data in the format defined in the Process Integration Attachment.

Claim Audits

The delegate is expected to allow Humana, or its designee, to perform periodic audits in order to monitor the effectiveness and quality of the delegate's claims processing functions. These audits include, but are not limited to, a review of:

- Delegate's overall claims process including policies and procedures
- Calculation of claims processing cycle time for the period under review
- Volume and age of pending claims
- Volume and age of claims inventory
- Claim and encounter submission (refer to the contract Process Integration Attachment for requirement details)
- Part C reporting accuracy on Medicare claims payment of interest on overdue claims (where required)
- Testing for financial accuracy on paid claims and member responsibility for denied claims
- Reporting accuracy for CMS monthly reports (i.e., ODAG, SARAG, PDLM)
- Third-party administrator license (where required)
- Financial solvency

- Monthly queries for the excluded persons and/or sanctioned provider lists for Medicare and/or Medicaid
- Compliance with Humana, HIPAA and ERISA requirements

In order for Humana, or its designee, to perform these periodic audits, the delegate may be asked to provide the following:

- A universe of previously processed claims for the period under review
- Copies of the sample claims selected for review
- Screen prints of the adjudication screen from the delegate's claims system
- Copies of the cancelled checks, EOB and/or remittance advice for each paid claim
- Copies of ERISA standard extension/delay letters issued (if applicable)
- Documentation of the interest payment and calculation (if applicable)
- Copies of the executed provider contracts for sample claims selected for review
- Applicable fee schedule information for sample claims selected for review
- Documentation of referrals for sample claims selected for review
- Any other information pertinent to the claim payment/denial for sample claims selected for review
- Report of claims currently pended or untouched
- Claims policies and procedures
- Copies of the member denial letter (when applicable) or provider explanation of benefits for each denied claim
- Copies of the delegate's most recent internal audit report (or internal financial statements if no audit is conducted) and supporting financial statements (income statement, balance sheet, cash flow statement and notes to financial statements). If no independent audit is conducted, copies of the most recently completed internally prepared balance sheet, income statement and cash flow statement should be provided, along with an attestation statement signed by the executive director or CFO stating the information is correct to the best of his/her knowledge.

Reporting Requirements

Humana/ChoiceCare requires all claims delegates to provide periodic reports for ongoing monitoring of the claims process. The following reports are required to be submitted to Humana:

- Monthly cycle time reports due by the 15th of the following month
- Medicare Part C reports due by the 15th following the end of the quarter
- Non-participating provider disputes where applicable

Humana/ChoiceCare will provide the template and submission process for each report. In addition, reporting requirements may change to comply with federal and state requirements or Humana standards. Any changes will be communicated to the delegate at such time.

Continuous Quality Improvement

All delegates are expected to function within a framework of continuous quality improvement and cooperate with Humana's quality improvement program. Additionally, some MBHOs, or other entities, may be delegated for a formal

quality improvement function. This includes the following:

- Select quantifiable standards, goals and benchmarks for each monitoring activity.
- Collect, analyze and discuss data for each monitoring activity. At a minimum, the delegate’s QI committee should discuss the data. Humana should approve data collection methods.
- Plan and implement corrective actions to improve performance.
- Remeasure to determine success of corrective action interventions.
- Cite quantifiable care and service improvements related to the tracking and trending of Humana member inquiries and verbal complaints when complaint management is delegated.

Credentialing Requirements

The delegate is to comply with Humana’s credentialing and recredentialing requirements, all applicable state and federal laws, rules and regulations and accreditation organization requirements pertaining to credentialing and/or recredentialing. This includes maintaining a credentialing committee, a credentialing and recredentialing program and all related policies, procedures and processes in compliance with these requirements.

Credentialing and Recredentialing Requirements

Practitioner Credentialing	Responsibility of Delegate	Responsibility of Delegator
a. Verification of current, valid state license(s)	X	
b. Verification of current, valid DEA or CDS certificate(s)	X	
c. Verification of education and training at initial credentialing, if not board certified	X	
d. Verification of board certification, if applicable	X	
e. Collection of five (5) year work history at initial credentialing	X	
f. Verification of National Practitioner Data Bank (NPDB)*	X	
g. Verification of professional liability claims history	X	
h. Verification of state license sanctions or restrictions	X	
i. Verification of Medicare and Medicaid sanctions <ul style="list-style-type: none"> • DHHS OIG List of Excluded Individuals and Entities (LEIE), or • NPDB query 	X	
j. Verification of Medicare Opt-Out*	X	
k. Verification of Clinical Privileges*	X	
l. Collection of current malpractice insurance coverage	X	
m. Verification of Medicare and Medicaid Eligibility* <ul style="list-style-type: none"> • GSA Excluded Parties Lists System (EPLS)/SAM and • Any applicable state eligibility or exclusion list 	X	

Practitioner Credentialing	Responsibility of Delegate	Responsibility of Delegator
n. Collection of applications, reapplications and signed attestation that addresses: <ul style="list-style-type: none"> • Inability to perform the essential functions of the position, • Lack of present illegal drug use, • History of loss of license and felony conviction, • History of loss or limitation of privileges or disciplinary activity, • Signed and dated attestation to the correctness and completeness, • Signed and dated consent form and • State Mandated application, if applicable 	X	
o. Performance monitoring at recredentialing:* <ul style="list-style-type: none"> • Information from quality improvement activities and • Member complaints (PCPs) 	X	
p. Credentials committee review/decision	X	
q. Practitioner appeals process	X	
r. Conduct site visits that are required by law to be completed as part of the initial or recredentialing file, if required by your state	X	
s. Collect and evaluate ongoing monitoring of sanctions and complaints <ul style="list-style-type: none"> • Complaints, • Medicare/Medicaid sanctions, • State license sanctions, • Medicare opt-out* and • Medicare and Medicaid eligibility* 		X
t. Conduct oversight audits		X
u. Retain the right to approve, deny, terminate or suspend new or renewing practitioners and organizational providers from participation in any of Delegator's networks		X
v. Collects semi-annual reports		X

*Medicare and/or Medicaid only

Access to Files

The delegate will provide Humana with access to credentialing/recredentialing documentation, processes, policies, systems and files (excluding any privileged peer review information that by law cannot be disclosed), for review upon request.

The delegate agrees that upon the termination of the delegated function, any files, records and documentation or quality copies of such files and documentation pertaining to Humana participating providers, which is necessary for Humana to resume responsibility for the delegated function, will be made available to Humana prior to termination of the function or at a minimum 15 business days after such termination.

Annual Review and Compliance

At least annually, Humana performs a review of the delegate's credentialing and recredentialing performance/compliance. Humana/ChoiceCare will provide the delegate with at least 30 days prior notification of such reviews.

This includes a review of any credentialing and/or recredentialing files, credentialing and recredentialing policies and procedures and credentials committee meeting minutes.

All elements of credentialing and/or recredentialing activities and functions that are delegated require a minimum of 95 percent compliance. Failure to meet compliance requirements will result minimally in a corrective action plan (CAP) and may result in revocation of the delegated activities.

Sub-delegation of Credentialing

If delegate sub-delegates or subcontracts any portion of the delegated functions to another entity (Subcontractor), then delegate will need to provide Humana with documentation of subcontractor's compliance and demonstrate oversight of subcontractor prior to the sub-delegation and annually thereafter. Humana retains the right to perform additional evaluation and oversight of the subcontractor, if deemed necessary by Humana.

Reporting Requirements

Complete listings of all participating providers credentialed and/or recredentialed are due on a semiannual basis. In addition, delegate should submit reports to Humana of all credentialing approvals and denials within 30 days of the final credentialing decision date. Delegate should include the elements indicated below in credentialing reports to Humana:

- Physician name
- Degree
- Practicing specialty
- NPI number
- Initial credentialing date
- Last recredentialing date
- State of practice

Resources

There are several resources available to answer questions regarding policies, procedures, addresses for submission of information and reports and other administrative tasks required of delegates such as:

- **Provider Representatives** – located in local Humana market offices or call Humana Customer Service 1-800-4HUMANA (1-800-448-6262).
- **ChoiceCare Provider Relations Department** – Telephone: 1-800-626-2741.
- **Provider Deployment Team** – assists in establishing electronic connections with Humana. Such electronic connectivity is important for submission of claims and encounters, verifying member eligibility, checking member benefits and more. The name and phone number of the Humana connectivity consultant for specific areas is available on [Humana.com/Providers](https://www.humana.com/providers), or by calling customer service (1-800-HUMANA) for this information.
- **Provider Financial Reporting Team** – educates the delegate's staff on the various financial reports issued by Humana. Call the local Humana market representative or Humana Customer Service: 1-800-4HUMANA (1-800-448-6262).
- **Delegation Compliance Team** – performs audits and assists in support and education of the delegate. Delegation

compliance consultants are available to answer compliance-related issues pertaining to delegated functions. These associates are also responsible for the auditing and monitoring activities to determine if the delegate is capable of handling the delegated activity in compliance with regulatory, accreditation and Humana/ChoiceCare requirements.

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